AMENDMENT and RESTATEMENT

It is agreed by and between the State of Vermont, Department of Vermont Health Access (hereafter called the "State" or "DVHA") and OneCare Vermont Accountable Care Organization, LLC. (hereafter called the "Contractor" or "OneCare") that the contract on the subject of Contractor's services as an Accountable Care Organization Pilot Project for a portion of Vermont's Medicaid Program, effective January 1, 2017, is hereby amended effective September 1, 2017, as follows:

1. **Parties (Restated).** This is a contract for services between the State of Vermont, Department of Vermont Health Access (hereafter called "State" or "DVHA"), and OneCare Vermont Accountable Care Organization, LLC., with a principal place of business in 356 Mountain View Drive, Colchester, Vermont 05446. (hereafter called "Contractor" or "OneCare"). The Contractor's form of business organization is a Limited Liability Corporation. The Contractor's local address is 356 Mountain View Drive, Colchester, Vermont 05446. It is the Contractor's responsibility to contact the Vermont Department of Taxes to determine if, by law, the Contractor is required to have a Vermont Department of Taxes Business Account Number.

2. **Subject Matter (Restated).** The subject matter of this contract is OneCare's services as an Accountable Care Organization Pilot Project for a portion of Vermont's Medicaid Program. Detailed services to be provided by the Contractor are described in Attachment A.

3. **Maximum Amount (Restated).** In consideration of the services to be performed by OneCare, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed $93,357,767.52.

4. **Contract Term (Restated).** The period of Contractor's performance shall begin on January 1, 2017 and end on December 31, 2017. At DVHA's discretion, the State may continue the contract with OneCare for four (4) additional one-year periods. Option year period selection shall be made by giving notice by September of the prior Performance Year. OneCare must consent to renew the Agreement for each option year exercised by DVHA.

5. **Prior Approvals (Restated).** If approval by the Attorney General's Office or the Secretary of Administration is required, (under current law, bulletins, and interpretations), neither this contract nor any amendment to it is binding until it has been approved by either or both such persons.

   Approval by the Attorney General's Office is required.
   Approval by the Secretary of Administration is required.

6. **Amendment (Restated).** No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and Contractor.

7. **Contacts and Notices (Restated):**

To the extent notices are made under this agreement, such notices shall only be effective if committed to writing and sent to the following persons as representatives of the parties:

CONTRACTOR:

Victoria Loner
Vice President
OneCare
356 Mountain View Drive
Colchester, VT 05446
Victoria.Loner@OneCareVT.org

STATE:

DVHA, Commissioner's Office
Department of Vermont Health Access (DVHA)
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
AHS.DVHALegal@vermont.gov

Written notices may be sent by electronic mail except for the following notices, which must be sent by United States Postal Service certified mail: termination of contract, contract actions, damage claims, breach notifications, alteration of this paragraph.

The contacts for this award are as follows:

	State Fiscal Manager	State Program Manager	For the Contractor
Name:	Michael Costa	Alicia Cooper	Victoria Loner
Phone #:	802-498-8686	802-585-4860	802- 847-6255
E-mail:	Michael.Costa@Vermont.gov	Alicia.Cooper@Vermont.gov	Victoria.Loner@OneCareVT.org

8. **Cancellation (Restated).** This contract may be terminated for three reasons:

(A) Either party can terminate the contract for cause upon written notice as described in section seven (7) above,
(B) Either party may terminate the contract without cause. A no-cause termination may be made by either party by providing 180 calendar day advance written notice to the other party in accordance with the provisions in section seven (7) above,
(C) the State may cancel this contract upon immediate notice in the event of the failure of appropriations with no obligation to pay for services after the date of termination.

After notice of intent to terminate or actual termination for any reason, the parties will meet after notice is provided and create a plan to:
1. Turn over records to DVHA,
2. Turn over financial records to DVHA,
3. Turn over other recordation required in this contract necessary for audit of the program,
4. Turn over other records.

Notwithstanding anything to the contrary in any portion of this Contract, DVHA agrees that after execution of this Agreement, but before February 1, 2017, OneCare intends to test and verify the financial projections in this Agreement. Upon review of the financial and actuarial data, OneCare may unilaterally terminate the Agreement, without cause, without any financial consequences, financial or otherwise. OneCare agrees that DVHA may review the same data and unilaterally terminate the contract before February 1, 2017.

9. **Attachments (Restated).** This Amendment and Restatement consists of 120 pages including the following attachments, which are incorporated herein:

Attachment A - Specifications of Work to be Performed

Exhibit 1 – Included and Excluded Service Codes
Exhibit 2 – Attribution Technical Specifications
Attachment B - Payment Provisions
Attachment C – Standard State Provisions for Contracts and Grants
Attachment D - Modifications of Customary Provisions of Attachment C or Attachment F
Attachment E - Business Associate Agreement
Attachment F - Agency of Human Services' Customary Contract Provisions

The order of precedence of documents shall be as follows:

1). This document
2). Attachment D
3). Attachment C
4). Attachment A (with exhibits)
5). Attachment B
6). Attachment E (if any)
7). Attachment F
8). Other Attachments (if any)

10. **Discretion (Restated)**. The Parties each acknowledge their duty of good faith and fair dealing in the exercise of any discretion with respect to this Agreement.

11. **By deleting Attachment A (Specifications of Work to be Performed) and its Exhibits 1 and 2 on pages 4 thru 77 of the Base Agreement, and substituting in lieu thereof the following Attachment A beginning on page 5:**

12. **By deleting Attachment B (Payment Provisions) on pages 78 thru 92 of the Base Agreement, and substituting in lieu thereof the following Attachment B beginning on page 82:**

13. **By restating Attachment C (Standard State Provisions for Contracts) on pages 93 through 98 of the Base Agreement, beginning on page 99:**

14. **By restating Attachment D (Modifications of Customary Provisions of Attachments C and F) on pages 99 through 100 of the Base Agreement, beginning on page 105:**

15. **By deleting Attachment E (Business Associate Agreement) on pages 101 thru 107 of the Base Agreement, and substituting in lieu thereof the following Attachment E beginning on page 107:**

16. **By restating Attachment F (Agency of Human Services' Customary Contract Provisions) on pages 108 through 113 of the Base Agreement, beginning on page 114:**

17. **By restating Subcontractor Compliance Form on page 114 of the Base Agreement, beginning on page 120:**

18. **Taxes Due to the State.** Contractor further certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, the Contractor is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due the State of Vermont.

19. **Certification Regarding Suspension or Disbarment**. Contractor certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for

debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing-contracting/debarment.

20. **Child Support** (Applicable to natural persons only; not applicable to corporations, partnerships or LLCs):

Contractor is under no obligation to pay child support or is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date of this amendment.

This amendment consists of 120 pages. Except as modified by this amendment and restatement and any previous amendments, all provisions of this contract, (#32318) dated February 1, 2017 shall remain unchanged and in full force and effect.

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

BY THE STATE OF VERMONT:

e-Signed by Cory Gustafson on 2017-09-27 16:18:02 GMT — September 27, 2017

CORY GUSTAFSON, COMMISSIONER — DATE
AHS/DVHA
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
Phone: (802) 241-0246
Email: Cory.Gustafson@vermont.gov

BY THE CONTRACTOR:

e-Signed by Todd Moore on 2017-09-27 13:51:55 GMT — September 27, 2017

TODD MOORE, CHIEF EXECUTIVE OFFICER — DATE
OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive
Colchester, VT 05446
Phone: (802) 847-1844
Email: Todd.Moore@OneCareVT.org

ATTACHMENT A
SPECIFICATIONS OF WORK TO BE PERFORMED

1.0 Attribution Methodology

1.1 Introduction and Overview

This section describes the methods that will be used for attributing Department of Vermont Health Access (DVHA) members to the Accountable Care Organization (ACO). It also describes the expenditure data that will be used to set actuarial rates.

DVHA intends to follow the methodology set forth by the Centers for Medicare & Medicaid Services' (CMS) Next Generation methodology using the full risk capitation method. CMS refers to this at the All-Inclusive Population-Based Payment (AIPBP). One difference from the CMS Next Generation model is that DHVA is using a larger set of Evaluation and Management (E&M) codes used in the attribution process. In this Contract, DVHA will use the same E&M codes used in the State of Vermont's Blueprint for Health program and in DVHA's current Vermont Medicaid Shared Savings Program.

The capitation rates, or AIPBP, will be set based on the actual attributed lives to the Contractor using the attribution methodology described in this Section 1, Attribution Methodology.

Throughout this Agreement, the term "members" means Medicaid beneficiaries who are members of DVHA's public managed care organization. The term "attribution" is synonymous with the Next Generation term "alignment".

1.2 Definitions

This section defines certain terms that are used to describe the attribution process.

1.2.1 Performance Year, Base Year, Attribution Years

Performance Year (PY) refers to the first year of this Contract, in this case, Calendar Year 2017.

Base Years (BYs) refers to those years of data used in establishing expenditure trends to inform the setting of capitation rates, in this case, Calendar Years 2013, 2014 and 2015.

Attribution Years (AYs) refers to those two historic years of data used to conduct the prospective attribution to each of the BYs and the PY. For example, the AYs used for the PY are the time periods representing State Fiscal Years 2015 and 2016.

The table below shows the time periods covered in the performance year, base years and attribution years.

Period	Period covered	Corresponding Attribution Years (AY)
Performance Year 2017 (PY)	01/01/2017 – 12/31/2017	AY1: 07/01/2014-6/30/2015 AY2: 07/01/2015-6/30/2016
Base Year 3 (BY3)	01/01/2015 – 12/31/2015	AY1: 07/01/2012-6/30/2013 AY2: 07/01/2013-6/30/2014

Base Year 2 (BY2)	01/01/2014 – 12/31/2014	AY1: 07/01/2011-6/30/2012 AY2: 07/01/2012-6/30/2013
Base Year 1 (BY1)	01/01/2013 – 12/31/2013	AY1: 07/01/2010-6/30/2011 AY2: 07/01/2011-6/30/2012

1.2.2 Attribution-eligible member

DVHA members must have at least one month of Medicaid enrollment in either of the two attribution years in order to be considered for attribution.

Newborns, i.e. infants born to DVHA member mothers who are attributed to OneCare that are born after June 30, 2016 will not be attributed to OneCare in Performance Year 2017. The Parties will mutually agree on how newborns born after December 31, 2017 will be attributed.

A DVHA member is not eligible for attribution in the Performance Year if the member falls into any of the following categories during the corresponding Attribution Years:

a. The DVHA member did not have any paid Qualified Evaluation and Management (QEM) service claims.

b. The DVHA member is dually eligible for Medicare;

c. The DVHA member had evidence of third party liability coverage;

d. The DVHA member is eligible for enrollment in Vermont Medicaid but has obtained coverage through commercial insurers;

e. The DVHA member is enrolled in Vermont Medicaid but receives a limited benefit package; or

f. The DVHA member is not enrolled as a DVHA member at the start of the Performance Year.

1.2.3 Monthly exclusion of members during the performance year

DVHA members will be prospectively attributed to the ACO at the start of the Performance Year. Attribution-eligibility requirements will be applied during the Performance Year as part of a monthly exclusion process.

DVHA's fiscal agent will exclude DVHA members from attribution who became ineligible for attribution in the previous month either due to one of the criteria stated in section 1.2.2 or as a result of the death of the member. If it is determined that capitation payments were unknowingly made in any month prior to the knowledge of one of these criteria, the capitation payments will be recouped and applied against a final year-end reconciliation for the Performance Year. The recouped capitation payments shall be pro-rated to reflect the months that the DVHA member was appropriately attributed to Contractor.

1.2.4 Qualified Evaluation and Management (QEM) services

QEM services are identified by the combination of Healthcare Common Procedure Coding System (HCPCS) codes, CPT codes and physician specialty. The HCPCS and CPT codes used are listed in Attachment A, Exhibit 2, Table 1.

In the case of claims submitted by physician's practices and institutional providers, a QEM service must be provided by a physician specialty listed in Attachment A, Exhibit 2, Table 2 or Table 3.

For purposes of this section Attachment A, Exhibit 2, Table 2 shall include physician assistants. If not already included, for purposes of this section Attachment A, Exhibit 2, Table 3 shall be deemed to include nurse practitioners and physician assistants who work in specialty care (by way of example and not limitation, cardiology or neurology).

1.2.5 Primary care practitioners

A primary care practitioner is a physician or non-physician practitioner (NPP) whose principal specialty is included in Attachment A, Exhibit 2, Table 2.

For purposes of applying the 2-stage attribution algorithm described below in 1.3.2, the provider specialty will be determined based on the specialty associated with the QEM as described in Section 1.2.4.

1.2.6 Participating provider

A participating provider is either a physician or a NPP who is a member of a participating practice or an institutional provider or a supplier that has entered into an agreement with the ACO.

In the case of physician practices and institutional practices, participating providers are identified by a combination of:

a. Taxpayer Identification Number (TIN) and
b. Medicaid provider identification numbers.

1.2.7 Participating practice

A participating practice is identified by the TIN and may include the following:

- A physician practice;
- A Critical Access Hospital;
- A Federally Qualified Health Center; or a
- A Rural Health Clinic

1.2.8 Participating practitioner

A participating practitioner is a physician or NPP identified by a Medicaid provider identifier, derived from the variable MC024 in the VHCURES data, who is a member of a participating practice.

1.2.9 Legacy practices

A legacy practice is a TIN that was used by a participating practice to bill for services provided to Medicaid members in an Attribution year or for any of the Base years but not during the Performance Year.

Legacy practices may be used to conduct attribution only if:

- Merger, acquisition, or corporate reorganization has resulted in the consolidation or replacement of a TIN that appears on claims for QEMs provided during an attribution-year; and

- The TIN will not be used to bill for QEM services provided during the Performance Year.

1.2.10 Expenditures used in the financial calculations

In general, and subject to the exceptions discussed below, the expenditures incurred by an attribution-eligible member, for purposes of financial calculations for any performance or baseline period, is the sum of all Medicaid payments on claims for services covered by DVHA, subject to the adjustments described in this section, including:

a. Inpatient claims,
b. Outpatient claims,
c. Physician claims,
d. Home Health Agency (HHA) claims,
e. Durable Medical Equipment (DME) claims,
f. Hospice claims (excluding hospice room and board), and
g. Care coordination fees

Refer to Exhibit 1 to Attachment A (Included and Excluded Service Codes) for a detailed listing of the codes that represent the services included or excluded from the financial calculations and Exhibit 2 to Attachment A (Attribution Technical Specifications) for Evaluation and Management Services coding.

1.2.11 Three-month run out

The expenditure that is used in financial calculations is the total amount paid to providers for services covered by DVHA that are incurred during the Base Year or Performance Year and paid within three months of the close of the Base Year or Performance Year.

1.2.12 Care coordination fees

Some payments made under care coordination programs that are tied to coordination of services provided to identifiable members but are paid outside the standard claims systems will also be included in the calculation of the baseline and performance period expenditures. These financial transactions include:

- Primary care case management (PCCM) payments to attributed members

Notwithstanding the foregoing paragraph, a fee of $2.50 per member per month is the only care coordination fee included in the calculation of baseline and performance period expenditures. DVHA shall provide OneCare on a monthly basis, no later than the 10th of each month, with a

report containing member level detail that identifies the total sum of care coordination fees paid to OneCare in the prior month.

1.2.13 Exclusion of certain provider payments

Within the scope of services defined in Section 1.2.10, further exclusions of certain provider payments from the calculation of medical expenses include:

- Graduate Medical Education (GME) payments
- Electronic Health Record (EHR) incentive payments
- Disproportionate Share Hospital (DSH) payments
- Any service funded through the Agency of Human Services outside of a DVHA fund source. The fund sources excluded are shown in Exhibit 2 to Attachment A, Table 4.
- Nursing home payments

1.3 Attribution of members

The members aligned with an ACO will be identified prospectively prior to the start of the Performance Year. Similarly, the members who are attributed in each Base Year are identified on the basis of each member's use of QEM services in the two-year attribution period ending prior to the start of the Base Year. Refer back to the table in 1.2.1 for the attribution time periods tied to each Base Year.

Attribution of the DVHA member is determined by comparing:

- The weighted paid claims for all QEM services that the member received from each ACO's participating providers;

- The weighted paid claims for all QEM services that the member received from each physician practice (including institutional providers) whose members are not participating in the ACO.

A member is aligned with the ACO or physician practice from which the member received the largest amount of QEM services during the two-year attribution period.

Only claims that are identified as being provided by the primary care specialist listed in Exhibit 2 to Attachment A, Table 2 and the non-primary care specialists listed in Exhibit 2 to Attachment A, Table 3 will be used in the attribution calculations.

The weighted claims for all ACO providers is a "combined total" of all the ACO providers versus the "combined total" of all non-ACO providers, by way of example the beneficiary below would be attributed to the ACO:

ACO Provider A	10%	Non ACO Provider E	19%
ACO Provider B	10%	Non ACO Provider F	24%
ACO Provider C	12%		
ACO Provider D	25%		
Total ACO	**57%**	**Total Non ACO**	**43%**

1.3.1 Use of weighted paid claims in attribution

The payment amount on paid claims for services received during the two Attribution Years associated with each Base Year or Performance Year will be used to determine the ACO or physician practice from which the member received the most QEM services and is weighted as follows.

a. The payments for QEM services provided during the 1st (earlier) Attribution Year will be weighted by a factor of ⅓.

b. The payments for QEM services provided during the 2nd (later or more recent) Attribution Year will be weighted by a factor of ⅔.

The payments that will be used in attribution will be obtained from claims for QEM services that are:

a. Incurred in each Attribution Year as determined by the date of service on the claim line-item; and,

b. Paid within three months following the end of the 2nd Attribution Year as determined by the effective date of the claim.

1.3.2 The 2 stage attribution algorithm

Attribution for a Base Year or Performance Year uses a two-stage attribution algorithm:

a. *Attribution based on primary care services provided by primary care specialists*. If 10% or more of the payments incurred on QEM services received by a member during the two-year attribution period are obtained from physicians and practitioners with a primary care specialty as defined in Attachment A, Exhibit 2, Table 2, then attribution is based on the payments on QEM services provided by primary care specialists.

b. *Attribution based on primary care services provided by selected non-primary care specialties*. If less than 10% of the QEM service payments are received by a member during the two-year attribution period are provided by primary care providers (step 1 above), then attribution is based on the QEM services provided by physicians and practitioners with certain non-primary specialties as defined in Attachment A, Exhibit 2, Table 3.

1.3.3 Tie-breaker rule

In the case of a tie in the dollar amount of the weighted payments for QEM services, the member will be attributed to the provider from whom the member most recently obtained a QEM service.

1.3.4 Voluntary attribution

DVHA will not use the CMS Next Generation voluntary attribution methodology in Performance Year 2017 but will consider this option in future performance years.

2.0 Administrative Requirements

2.1 State Registration

Prior to the Contract Award, the Contractor must be registered as a business with the Vermont Secretary of State.

2.2 Accreditation / Licensure

OneCare agrees to comply with any state licensure requirement(s) for Accountable Care Organizations pursuant to Act 113 of 2016, on the effective date of such licensure requirement. If such requirement allows NCQA accreditation to be deemed to meet the state law requirement, OneCare may meet either requirement, at its discretion.

2.3 Contractor Governance

The Contractor must maintain an identifiable governing body that has responsibility for oversight and strategic direction that holds the Contractor's management accountable for its activities.

The Contractor must identify its board members, define their roles and describe the responsibilities of the board in writing to the State.

The Contractor's governing body must have a transparent governing process which includes the following:

1. Publishing the names and contact information for the governing body members, for example, on a website;
2. Devoting an allotted time at each in-person governing body meeting to allow comments from members of the public to be heard. Public participants must provide prior notice of intent to speak;
3. Providing updates on the Contractor's activities;
4. Making meeting minutes available to the Contractor's provider network upon request; and
5. Posting summaries of Contractor activities provided to the Contractor's consumer advisory board on its website.

The Contractor's governing body members shall have a fiduciary duty to the ACO and act consistently with that duty.

At least 50 percent of the voting membership of the Contractor's governing body must be held by or represent Contractor participants in order to provide for meaningful involvement of Contractor participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

a. Has a signed Participant Agreement and has programs designed to improve quality, patient experience, and manage costs;
b. Of the 50% participant membership required on the governing body:
    a. At least one seat must be held by a participant representative of the mental health and substance abuse community of providers; and
    b. At least one seat must be held by a participant representative of the post-acute care (such as home health) or long term care services and supports community of providers.
    c. Institutional and home-based long-term care providers, sub-specialty providers, mental health providers and substance abuse treatment providers are strongly encouraged to be invited to participate on ACO clinical advisory boards. This shall not be construed to create a right to participate or to be represented.

d. It is also strongly encouraged that ACO participant membership serving all ages of Medicaid members (pediatric and geriatric) be represented in governance and in clinical advisory roles. This shall not be construed to create a right to participate or to be represented.

Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. At least one consumer member must be a Medicaid member. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues or be trained in such advocacy. The Contractor's governing body shall consult with advocacy groups and organizational staff in the recruitment process for the consumer member.

The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

At any time during the period of this Contract, the Contractor shall adjust the composition and responsibilities of its governing body as may be mandated by ACO Governance Standards set by the Green Mountain Care Board for all ACOs in the state.

2.4 Administrative and Organizational Structure

The Contractor shall maintain an administrative and organizational structure that supports effective and efficient delivery of integrated services to its members. The organizational structure shall demonstrate a coordinated approach to managing the delivery of health care services to its members. The Contractor's organizational structure shall support collection and integration of data from every aspect of its delivery system and its internal functional units to accurately report the Contractor's performance. The Contractor shall also have policies and procedures in place that support the integration of financial and performance data and comply with all applicable federal and state requirements.

The Contractor shall have in place sufficient administrative and clinical staff and organizational components to comply with all contract requirements and standards. The Contractor shall manage the following major operational areas:

- Administrative and fiscal management
- Member services (but not Medicaid eligibility)
- Provider services (but not DVHA provider enrollment)
- Provider contracting (limited to contractual relationships between the Contractor and its provider network)
- Network development and management
- Quality management and improvement
- Utilization and care management

- Information systems
- Provider payments
- Performance data reporting and submission of provider payment transactions
- Member and provider grievances (state fair hearings will remain DVHA's responsibility)

2.5 Staffing

The Contractor shall have in place sufficient administrative, clinical and organizational staffing to comply with all program requirements and standards. The Contractor shall maintain a high level of Contract performance and data reporting capabilities regardless of staff vacancies or turnover. The Contractor shall have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment. These processes will be verified during the readiness review.

The Contractor shall have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (e.g., high school, college degree or graduate degree), professional credentials (e.g., licensure or certifications), work experience, membership in professional or community associations, etc.

2.5.1 Key Staff

The Contractor shall employ the key staff members listed below. The Contractor shall have an office in the State of Vermont from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities and a major portion of the Contractor's operations take place. The Contractor shall be responsible for all costs related to securing and maintaining this facility.

Upon award of the Contract, the Contractor shall deliver the final staffing plan, including all key staffing positions, within thirty (30) calendar days after notice of award.

The Contractor shall identify and disclose any staff or operational functions located outside the State of Vermont. If any staff or operational functions are located outside the State of Vermont, the Contractor shall ensure that these locations do not compromise the delivery of integrated services and the seamless experience for members and providers.

In the event of a vacancy of a key staff member for any reason, the Contractor shall notify DVHA in writing within five (5) business days of the vacancy and the Contractor's plan to fill the vacancy. As part of its annual and quarterly reporting, the Contractor must submit to DVHA an updated organizational chart including e-mail addresses and phone numbers for key staff.

The key staff positions include, but are not limited to:

DVHA Role Identified	OneCare Title Translation	OneCare Person Identified
CEO	CEO	Todd Moore, MBA
CFO	Director, Finance	Tom Borys, MBA
COO	COO	Victoria Loner, RN, MHCDS
Compliance Officer	Chief Compliance Officer	Jennifer Parks, JD

Data Compliance Manager	Director, Informatics	Leah Fullem, MHCDS
Director ACO Program Strategy and Development	Director ACO Program Strategy and Development	Martita Giard
Medical Director	Chief Medical Officer	Norman Ward, MD, MHCDS
Member Services and Provider Services Manager	Manager, ACO Operations	Shawntel Burke
Quality Improvement Manager	Director, Clinical and Quality Improvement	Sara Barry, MPH
Utilization Management Manager	Director, Clinical and Quality Improvement	Sara Barry, MPH

2.5.2 Staff Positions

In addition to the required key staff described in Section 2.5.1, the Contractor may employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Suggested staff include, but is not limited, to:

- **Compliance staff** to support the Compliance Officer and help ensure all Contractor functions are in compliance with state and federal laws and regulations, the State's policies and procedures and the terms of the Contract. This may include staff who will assist and interface with the DVHA Program Integrity Unit and help review and investigate Contractor's providers and members that are engaging in wasteful, abusive, or fraudulent billing or service utilization.

- **Member services representatives** to coordinate communications between the Contractor and its members; respond to member inquiries; and assist all members regarding issues such as the Contractor's policies, procedures, general operations, and benefit coverage.

- **Provider representatives** to develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers.

- **Grievance and appeals staff** necessary to investigate and coordinate responses to address member and provider grievances and appeals against the Contractor and interface with the DVHA Member and Provider Services staff.

- **Quality management staff** dedicated to perform quality management and improvement activities, and participate in the Contractor's internal Quality Management and Improvement Committee.

- **Utilization and medical management** staff dedicated to perform utilization management and review activities.

- **Care managers** who provide care management, care coordination and utilization management for high-risk or high-cost members.

- **Technical support services staff** to ensure the timely and efficient maintenance of information technology support services, production of reports, processing of data requests and submission of timely, complete and accurate encounter data.

- **Website staff** to maintain and update the Contractor's member and provider websites and member portal.

2.5.3 Training

On an ongoing basis, the Contractor must ensure that each staff person, including subcontractor staff, has appropriate education and experience to fulfill the requirements of their positions, as well as ongoing training specific to their role in the organization. The Contractor must ensure that all staff are trained in the major components of the Vermont Medicaid program.

Additionally, utilization management staff shall receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur.

The Contractor shall update its training materials on a regular basis to reflect program changes. The Contractor shall maintain documentation to confirm its internal staff training, curricula, schedules and attendance, and shall provide this information to DVHA upon request and during regular on-site visits. For its utilization management staff, the Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by DVHA.

2.5.4 Debarred Individuals

In accordance with 42 CFR § 438.610, the Contractor must not knowingly have a relationship with the following:

- An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, which relates to debarment and suspension; or

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

For purposes of this prohibition, the term relationships include directors, officers or partners of the Contractor, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

In accordance with 42 CFR § 438.610, if DVHA finds that the Contractor is in violation of this regulation, this shall be grounds for Contract termination.

The Contractor shall have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded. As part of readiness review, the Contractor shall demonstrate to DVHA that it has mechanisms in place to monitor staff and subcontractors for individuals debarred by Federal agencies.

The Contractor shall be required to disclose to the DVHA Program Integrity Unit information required by 42 CFR § 455.106 regarding the Contractor's staff and persons with an

ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that person's involvement in the Medicare or Medicaid program.

2.6 DVHA Meeting Requirements

The Contractor shall comply with all meeting requirements established by DVHA, and is expected to cooperate with DVHA and/or its contractors in preparing for and participating in these meetings. DVHA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

DVHA will meet at least annually with the Contractor's executive leadership to review the Contractor's performance, discuss the Contractor's outstanding or commendable contributions, identify areas for improvement and outline upcoming issues that may impact the Contractor or the Medicaid ACO program.

2.7 Financial Stability

DVHA will monitor the Contractor's financial performance. DVHA shall be copied on required filings with the Green Mountain Care Board related to the Contractor's financial stability.

2.7.1 Solvency

To provide evidence that OneCare has sufficient financial resources for the risk associated with year one of this contract, OneCare will provide a legally sufficient letter of credit in the amount of $2,800,733.03.

2.7.2 [intentionally omitted]

2.7.3 Financial Accounting Requirements

The Contractor shall maintain separate accounting records for its Medicaid line of business that incorporates performance and financial data of subcontractors, as appropriate, particularly risk-bearing subcontractors.

The Contractor shall notify DVHA of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and shall submit financial statements for these individuals or corporations.

Authorized representatives or agents of the State and the federal government shall have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction.

Copies of any accounting records pertaining to the Contract shall be made available by the Contractor within ten (10) calendar days of receiving a written request from the State for specified records. DVHA and other state and federal agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the Contract.

The Contractor shall maintain financial records pertaining to the Contract, including all claims records, for the period specified in the State's Customary Provisions for Contracts and Grants. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract.

DVHA will require Contractor to produce the information on the Contractor's financial condition at the close of its fiscal year and upon request by the DVHA Commissioner. Included with the financial information will be an opinion of an independent certified public accountant (CPA) on the financial statement of the Contractor. The CPA's certification shall represent whether the assets of the Contractor make adequate provision for any additional liability that may inure to the Contractor by virtue of its assumption of risk under a financial risk transfer agreement or any similar transaction. The amount and adequacy of any such liability shall be disclosed and commented upon by the CPA in its certification.

Any financial statement submitted to DVHA shall be sworn to under penalty of perjury by the Contractor's Director of Finance. Information in the financial statement submission shall include, but not be limited to:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance

At least annually, the Contractor shall provide to DVHA confirmation of appropriate insurance coverage for medical malpractice, general liability, property, workers' compensation and fidelity bond, in conformance with state and federal regulations.

DVHA may make an examination of the affairs of the Contractor as often as it deems prudent. The focus of the examination will be to ensure that the Contractor is not subject to adverse actions which in DVHA's determination have the potential to impact the Contractor's ability to meet its responsibilities with respect to its use of in-network capitation funds received from DVHA and the Contractor's compliance with the terms and conditions of any financial risk transfer agreement. Responses to DVHA requests shall fully disclose all financial or other information requested. Information designated as confidential may be not be disclosed by DVHA without the prior written consent of the Contractor except as required by law. If the Contractor believes the requested information is confidential and not to be disclosed to third parties, the Contractor shall provide a detailed legal analysis to DVHA setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

2.7.4 [intentionally omitted]

2.8 Reporting Transactions with Parties of Interest

The Contractor shall disclose to DVHA information on certain types of transactions they have with a "party in interest" defined as:

- Any director, officer, partner or employee responsible for management or administration of an ACO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the ACO; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of the ACO; and,

in the case of an ACO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

- Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the ACO; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the ACO;

- Any person directly or indirectly controlling, controlled by or under common control of the ACO; and

- Any spouse, child or parent of an individual described above.

Business transactions which shall be disclosed include:

- Any sale, exchange or lease of any property between the ACO and a party in interest;

- Any lending of money or other extension of credit between the ACO and a party in interest; and

- Any furnishing for consideration of goods, services (including management services) or facilities between the ACO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions between the Contractor and a party in interest listed above includes:

- The name of the party in interest for each transaction;

- A description of each transaction and the quantity or units involved;

- The accrued dollar value of each transaction during the fiscal year; and

- Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, the Contractor may be required to submit a consolidated financial statement for the Contractor and the party in interest.

2.9 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Contractor and any entity that performs delegated activities related to the Contract or any administrative entities not involved in the actual delivery of medical care, but performing delegated activities. By way of example, software vendors are not considered subcontractors, but case managers would be. Medicaid approved providers are excluded from the requirements and oversight of Section 2.9.

The Contractor is responsible for the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of the Contractor to the State to ensure that all activities under the Contract are carried out. The Contractor shall oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the Contractor's monitoring activities. The Contractor shall be held accountable for any functions and responsibilities that it delegates.

The Contractor shall provide that all subcontracts indemnify and hold harmless the State of Vermont, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. This indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary providers that have contracted with the Contractor.

The subcontracts shall further provide that the State shall not provide such indemnification to the subcontractor.

Contractor shall monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of DVHA capitation payments to the Contractor.

At least annually, the Contractor must obtain the following information from the subcontractor and use this information to monitor the subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance. The Contractor shall make these documents available to DVHA upon request and DVHA shall have the right to review these documents during Contractor site visits.

The Contractor shall comply with 42 CFR § 438.230 and the following subcontracting requirements:

- The Contractor shall obtain the approval of DVHA before subcontracting any portion of the project's requirements. The Contractor shall give DVHA a written request and submit a Subcontractor Compliance Form at least sixty (60) calendar days prior to the use of a subcontractor. The State will ensure that the proposed subcontractor (1) does not appear on the State's debarment list, and (2) that the work to be performed by the subcontractor is appropriate and in accordance with the scope and terms of the agreement. If the Contractor makes subsequent changes to the duties included in the subcontractor contract, it shall notify DVHA sixty (60) calendar days prior to the revised contract effective date and submit an updated Subcontractor Compliance Form for review and approval. DVHA must approve changes in vendors for any previously approved subcontracts.

- The Contract shall ensure the subcontractor is in full compliance with Attachment C regarding fair employment practices and the Americans with Disabilities Act, taxes due the State, child support orders (if applicable) and debarment.

- The State will not approve a subcontract involving offshore services.

- The Contractor shall evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the Medicaid ACO program.

- The Contractor shall have a written agreement with each subcontractor in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement shall be in compliance with the State of Vermont statutes and federal laws and will be subject to the provisions thereof.

- The Contractor shall collect performance data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews. The Contractor shall incorporate all subcontractors' data into the Contractor's performance and

financial data for a comprehensive evaluation of the Contractor's performance compliance and identify areas for its subcontractors' improvement when appropriate. The Contractor shall take corrective action if deficiencies are identified during the review.

- All subcontractors shall fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that apply to any service or activity delegated under the subcontract.

- The Contractor shall submit a plan to the State on how the subcontractor will be monitored for debarred employees.

- The Contractor shall assure the fulfillment of the requirements of 42 CFR § 434.6, which addresses general requirements for all Medicaid contracts and subcontracts.

The Contractor must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions and performance. The Contractor must integrate subcontractors' performance data (when applicable) into the Contractor's information system to accurately and completely report Contractor performance and confirm contract compliance.

DVHA shall have the right to audit the Contractor's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions and will assess liquidated damages for non-compliance with reporting requirements and performance standards.

If the Contractor uses subcontractors to provide direct services to members, the subcontractors shall meet the same requirements as the Contractor, and the Contractor shall demonstrate that the subcontractors are in compliance with these requirements. The Contractor shall require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

2.10 Confidentiality of Member Medical Records and Other Information

The Contractor shall ensure that member medical records as well as any other health and enrollment information that contains individually identifiable health information is used, stored/maintained and disclosed in accordance with the privacy requirements set forth in DVHA's Business Associate Agreement.

2.11 Response to State Inquiries

DVHA may directly receive inquiries and complaints from external entities, including but not limited to providers, members, legislators or other constituents which the Contractor will be required to research, respond to and resolve in the timeframe specified by DVHA.

2.12 Dissemination of Information

Upon the request of DVHA, the Contractor shall distribute information prepared by DVHA, its designee, or the Federal Government to its members.

2.13 Maintenance of Records

The Contractor, through its network participants, shall maintain medical records that fully disclose the extent of services provided to individuals under this program for a period of six (6) years in accordance with 42 CFR § part 455 and 45 CFR § 164.530(j)(2), or for the duration of contested case proceedings, whichever is longer.

The Contractor shall maintain all financial, quality measurement and other records that relate to the payments under this Agreement for a period of ten (10) years in accordance with the State's 1115a waiver document, or for the duration of contested case proceedings, whichever is longer.

2.14 Maintenance of Written Policies and Procedures

The Contractor shall develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, Vermont Statutes, DVHA Rules applicable to this Contract, ACO Operations Manual and the Contract. Written guidelines shall be maintained for developing, reviewing and approving all policies and procedures. The Contractor shall review all policies and procedures at least annually to ensure they reflect current practice and shall update them as necessary. Reviewed policies shall be signed and dated. All medical and quality management policies shall be reviewed and approved by the Contractor's Medical Director. DVHA has the right to review all Contractor policies and procedures. Should DVHA determine a policy requires revision, the Contractor shall work with DVHA to revise within the timeframes specified by the State. If DVHA determines the Contractor lacks a policy or process required to fulfill the terms of the Contract, the Contractor must adopt a policy or procedure as directed by DVHA.

2.15 Participation in Readiness Review

The Contractor must pass a readiness review process and be ready to assume responsibility for contracted services before the Contract effective date. The Contractor shall maintain a detailed implementation plan to be approved by DVHA which identifies the elements for implementing the proposed services. In addition to submitting the implementation plan with the proposal, the Contractor may be required to submit a revised implementation plan for review as part of the readiness review.

If DVHA determines at the conclusion of the readiness review that a functional area or areas are not ready, DVHA may, in its discretion, conduct a re-review at a later date. The re-review may occur prior to or after the start date of the Contract and will continue until the Contractor has passed DVHA's certification of readiness.

In preparation for planned onsite reviews, the Contractor shall cooperate with DVHA by forwarding in advance policies, procedures, job descriptions, contracts, reports, records, logs, and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities.

2.16 DVHA Ongoing Monitoring

DVHA shall conduct ongoing monitoring of the Contractor to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of DVHA and may include, but is not limited to, both scheduled and unannounced site visits, review of policies and procedures, and performance reporting.

In support of ongoing monitoring, DVHA will create two guidance documents that will be effective, and binding on Contractor, upon execution of the contract:

- The ACO Reporting Manual will contain a catalog of the reports that will be required to be submitted by the Contractor to DVHA and the periodicity schedule of each report submission. For every report, DVHA will provide both a report template and instructions for how to complete each report.

- The ACO Operations Manual will contain written procedures that will be created for each functional area, as needed, that pertain to the notifications, reporting, or file exchanges between the Contractor and DVHA.

The ACO is bound to ACO Reporting Manual and ACO Operations Manual changes. Both the ACO Reporting Manual and ACO Operations Manual will be considered "living" documents and will be updated, as needed, throughout the course of the contract.

2.17 Material Change

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of either 1) attributed members or 2) OneCare's provider network.

Prior to implementing a material change in operation, the Contractor shall submit a request to DVHA for review and approval at least sixty (60) calendar days in advance of the effective date of the change. The request shall contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. Contractor may be required, at the direction of DVHA, to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

No change will alter the capitation payments agreed to.

2.18 Future Program Guidance

In addition to complying with the ACO Operations Manual and ACO Reporting Manual, the Contractor shall operate in compliance with all future program manuals, guidance and policies and procedures, as well as any amendments thereto. Future modifications that have a significant impact on the Contractor's responsibilities, as set forth in this Scope of Work, will be made through the Contract amendment process.

3. Covered Services

3.1 Medical Necessity

The Contractor shall provide to its attributed Medicaid members, at a minimum, all benefits and services deemed "medically necessary" that are covered by Medicaid and included in the Contract with the State. Medical necessity is defined in the State's Medicaid Covered Services Rules as follows:

> "Medically necessary" means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

A. help restore or maintain the beneficiary's health; or
B. prevent deterioration or palliate the beneficiary's condition; or
C. prevent the reasonably likely onset of a health problem or detect an incipient problem.

For the purposes of this section, "Contractor shall provide" means the Contractor's network is required to provide medically necessary services. The Parties agree that OneCare does not directly deliver the service but does so through its contracted network.

The Contractor shall provide covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. Coverage may not be arbitrarily denied or reduced and is subject to certain limitations in accordance with 42 CFR § 438.210(a)(3)(iii), which specifies when Contractors may place appropriate limits on services:

- On the basis of criteria applied under the State Plan, such as medical necessity; or

- For the purpose of utilization control, provided the services furnished are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

3.2 Services Covered in the ACO Capitation Payment

The risk-based capitated payment to the Contractor includes payment for the following categories of services.

- Inpatient hospital services
- Outpatient hospital services
- Physician services, primary care and specialty
- Nurse practitioner services
- Ambulatory surgical center services
- Federally Qualified Health Center and Rural Health Clinic services
- Home health services
- Hospice services (excluding hospice room and board)
- Physical, occupational and speech therapy services
- Chiropractor services
- Audiology services
- Podiatrist services
- Optometrist and optician services
- Independent laboratory services
- Mental health and substance abuse services funded by DVHA and not funded by other State Departments; *however, H0001 – H2037 are excluded when billed on professional claims*
- Ambulance transport – emergent/non-emergent
- Durable medical equipment, prosthetics and orthotics (except eyewear)
- Medical supplies
- Dialysis facility services
- Preventive services
- Physician administered drug services billed on institutional claims
- Dental services billed on institutional claims

A detailed listing, by CPT/HCPCS, of services covered in the ACO capitation payment appears in Attachment A, Exhibit 1. Specific benefits/services and the limitations for these benefits/services are described in Vermont Medicaid Rules. The detailed listing in Attachment A, Exhibit 1 represents national coding conventions at the time of the release of this RFP. Coding conventions are periodically updated. DVHA will update Attachment A, Exhibit 1 on a periodic basis (no more frequently than quarterly), as necessary, and will include it as part of the ACO Operations Manual.

For the purposes of this section, "Contractor shall deliver" means the Contractor's network is required to deliver services in sufficient amount, scope, and duration. The Parties agree that OneCare does not directly deliver these services but OneCare does so through its contracted network.

3.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

EPSDT is a federally-mandated preventive health care program that provides early and periodic screening and diagnosis of eligible Medicaid beneficiaries under age 21 to ascertain physical and mental defects and to provide treatment to correct or ameliorate defects and chronic conditions found. The Contractor must provide all medically necessary covered EPSDT services under Section 3.2 of the Scope of Work in accordance with Federal law.

For covered EPSDT services, the Contractor shall comply with the requirements of 42 U.S.C. § 1396a (a) (43) and 42 U.S.C. § 1396d (r). These citations require the Vermont Medicaid Program to follow an immunization schedule recommended by the American Pediatric Association; it requires vision, dental, and hearing screenings at regular intervals; and it requires treatment of conditions found during screenings to correct or ameliorate those conditions.

Additionally, the contractor shall educate pregnant woman and work with prenatal clinics and other providers to educate pregnant woman about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants. The contractor shall educate parents of children under 21 years of age regarding preventive screenings.

For purposes of this section, the Parties agree that the term "the Contractor must provide" in the first paragraph and the "the Contractor shall educate" in the third paragraph means that the Contractor's network must provide medically necessary EPSDT services and must educate pregnant woman and certain providers. The Parties agree OneCare does not directly provide services or educate providers or members. The Parties agree that OneCare provides services through its contracted network.

3.4 Emergency Care and Post Stabilization

The Contractor shall cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider in accordance with and as defined in 42 CFR § 438.114.

The Contractor shall cover post-stabilization services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition in accordance with and as described in 42 CFR § 438.114(e).

For purposes of this section, the Parties agree that the term "the Contractor shall cover" shall mean the Contractor's network shall cover emergency services and cover post stabilization services. The Parties agree that OneCare does not directly provide health services but does so through its contracted network.

3.5 Self-referral Services

The Contractor shall provide female members attributed to the ACO with direct access to women's health specialists in accordance with 42 CFR § 438.206(b)(2).

The Contractor shall provide members attributed to the ACO with direct access to specialists for members in special healthcare needs populations as defined in Section 4.2.3 of this Scope of Work.

For purposes of this section, the Parties agree that the term "the Contractor shall provide" in the first and second sentences shall mean the Contractor's network shall provide attributed females access to women's health specialists and members with special health care needs with direct access to specialists. The Parties agree that OneCare does not directly provide health services but does so through its contracted network.

3.6 Services Not Covered in the ACO Capitation Payment

The following services are paid for by DVHA but are not included in the Contractor's capitated monthly rate:

- Pharmacy
- Physician administered drug services billed on professional claims
- Nursing facility care
- Psychiatric treatment in a state psychiatric hospital
- Level 1 (involuntary placement) inpatient psychiatric stays in any hospital when paid for by DVHA
- Dental services billed on professional claims
- Non-emergency transportation (ambulance transportation is not part of this category)
- Smoking cessation services
- Designated Agencies (DAs) and Specialized Service Agencies (SSAs)

Additionally, other services offered to Medicaid members but paid for by State Departments other than DVHA are not covered in the Contractor's capitated monthly rate, such as:

- Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by State Agencies other than DVHA
- Other services administered and paid for by the Vermont Department of Mental Health
- Services administered and paid for by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network
- Services administered by the Vermont Department of Disabilities, Aging and Independent Living
- Services administered and paid for by the Vermont Agency of Education
- Services administered and paid for by the Vermont Department of Health, including smoking cessation services

3.7 Continuity of Care

The Contractor shall implement mechanisms to ensure the continuity of care and coordination of medically necessary health care services for its members. The Contractor shall honor previous authorizations of services made by DVHA for a minimum of thirty (30) calendar days from the member's attribution with the Contractor. Contractor shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's attribution.

Additionally, when a member transitions out of the ACO, the Contractor shall be responsible for providing to DVHA, upon request, with utilization data and other applicable clinical information such as disease management, case management or care management notes.

If an ACO attributed member leaves the ACO during an inpatient stay, the Contractor will remain financially responsible for the hospital payment until the member is discharged from the hospital or the member's eligibility in Medicaid terminates.

For purposes of this section, the Contractor shall not require prior authorizations.

3.8 Enhanced Services

The Contractor is encouraged to provide programs that enhance the general health and well-being of its members, including programs that address preventive health, risk factors or personal responsibility.

Any enhanced services shall comply with the member incentives guidelines set forth in Section 8 of this Scope of Work and other relevant state and federal regulations regarding inducements. All enhanced services offered by the Contractor must be approved by DVHA prior to initiating such services.

For purposes of this section, the term "Enhanced Services" means any service not included in section 3.2 through and including section 3.5.

4.0 Member Services

4.1 Marketing and Outreach

In accordance with 42 CFR § 438.104, and the requirements outlined in Section 4.5, the Contractor may market itself to Medicaid members. However, if the Contractor chooses to conduct marketing activities, the Contractor shall obtain State approval for all marketing and outreach materials at least thirty (30) calendar days prior to distribution.

The Contractor may market by mail, mass media advertising (e.g., radio, television and billboards) and community-oriented marketing directed at potential members. The contractor shall not design their marketing efforts in such a way that the marketing materials target groups with favorable demographics or healthcare needs.

Any outreach and marketing activities (written and oral) shall be presented and conducted in an easily understood manner and format and at a sixth grade reading level. The Contractor shall not engage in marketing activities that mislead, confuse or defraud members or the State. Statements considered inaccurate, false, or misleading include, but are not limited to, any assertion or written or oral statement that:

- The member or potential member must join the Contractor's ACO to obtain benefits or to avoid losing benefits;
- The Contractor is endorsed by CMS, the federal or state government or a similar entity; or
- The Contractor's ACO plan is the only opportunity to obtain benefits under the State of Vermont's Medicaid program.

4.2 Member Attribution to the ACO

The attribution of DVHA members to an ACO will be prospective and will be based on the individual's prior utilization with either a Primary Care Provider (PCP) or selected specialist providers. The Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to attribute to the ACO. Additionally, the Contractor shall not discriminate against individuals eligible to attribute on the basis of race, color, national origin, or sexual orientation and will not use any policy or practice that has the effect of discriminating in such manner.

4.2.1 [intentionally omitted]

4.2.2 Special Healthcare Needs Populations

The Contractor shall have plans for provision of care for the special healthcare needs populations and for provision of medically necessary, specialty care through direct access to specialists. Under this contract, the definition and reference for children with special health care needs is the one adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

> "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

In accordance with 42 CFR § 438.208(c)(2), which specifies allowable staff, the Contractor shall have a *health care professional* assess the member through a detailed health assessment if a health screening identifies the member as potentially having a special health care need. CMS has identified the following populations as meeting the statutory definition of "special healthcare populations" pursuant to 42 CFR § 438.208:

- Adults in the Community Rehabilitation Services program,
- Children in the Enhanced Family Treatment program,
- People with traumatic brain injuries,
- Children in the high-tech needs program,
- Individuals with developmental disabilities, and
- People receiving Home and Community Based Services.

The Contractor shall offer continued coordinated care services to any special health care needs members transferring into the Contractor's membership.

For purposes of this section, the terms "the Contractor shall have plans," "the Contractor shall have a health care profession," and "the Contractor shall offer" mean that the Contractor's network shall fulfill those requirements. The Parties agree that OneCare does not directly provide services but does so through its contracted network.

4.2.3 Member Termination from the ACO

Notwithstanding anything to the contrary in the ACO Operations Manual, in the event that Contractor learns that a member has become deceased, Contractor may, at its option, share the information available to it with DVHA.

In the event of the death of an ACO attributed member, the ACO shall receive fifty percent (50%) of the usual capitation payment for any member who dies on or before the 15th calendar day of the month. The recoupment of any capitation payments made to the Contractor due to the death of an ACO attributed member will occur during the year-end reconciliation process.

4.3 Member-Contractor Communications

4.3.1 Member Services Helpline

The State shall continue to maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the Vermont Medicaid program as well as basic information about the ACO's programs. The State's Member Services Helpline is intended to be equipped to handle a variety of basic, first tier member inquiries, including the ability to address member questions, concerns, complaints and requests for PCP changes.

The Contractor shall be responsible for its own Member Services Helpline to handle second-tier questions from members (including issues that require specific expertise and authority by the Contractor to resolve). Staff assigned to this function must be available to provide sufficient "live voice" access to members during, at a minimum, the hours between 8 a.m. and 6 p.m. Eastern Standard Time, Monday through Friday. The Contractor shall provide an after-hours voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day. During hours of operation, the Contractor must be able to receive transfers from DVHA's Member Services Helpline, AHS staff and members who wish to directly call the ACO.

The Contractor's helpline may be closed on all holidays observed by the State government. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The Contractor's helpline shall offer language translation services for members whose primary language is not English and shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members.

The Contractor's Helpline staff shall be trained to ensure that member questions and concerns are resolved as expeditiously as possible. The Contractor shall maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor shall monitor its member services helpline service and report its telephone service level performance to DVHA in the timeframes and specifications described in the ACO Reporting Manual.

Upon a member's joining the ACO, the Contractor shall inform the member about the State's Member Services Helpline as well as the Contractor's Helpline.

The Contractor must meet the following performance standards related to the responsiveness of staffed telephone lines:

- During open hours, seventy-five percent of all incoming calls that opt to talk to a live operator are answered by a live operator within 25 seconds of leaving the contractor's Interactive Voice Response (IVR) system;
- Lost call abandonment rate after the call exits the IVR shall not exceed five percent. 98% of calls are answered by a live agent within four minutes.

4.3.2 Electronic Communications

The Contractor shall provide an opportunity for members to submit questions or concerns electronically, via e-mail and through the member website.

The Contractor shall respond to questions and concerns submitted by members electronically within one (1) business day. If the Contractor is unable to answer or resolve the member's question or concern within one business day, the Contractor shall notify the member that additional time will be required and identify when a response will be provided. A final response shall be provided within three (3) business days.

The Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. The Contractor shall be prepared to provide this information to DVHA upon request.

4.4 Member Information, Outreach and Education

The Contractor shall inform members that information is available upon request in alternative formats and how to obtain them. DVHA defines alternative formats as Braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. To the extent possible, written materials shall not exceed a sixth grade reading level.

The Contractor shall inform the members that, upon the member's request, the Contractor will provide information on the structure and operation of the Contractor and, in accordance with 42 CFR § 438.6(h), will provide information on the Contractor's provider incentive plans.

The Contractor shall be responsible for developing and maintaining member education programs designed to provide the members with clear, concise and accurate information about the Contractor's program and the Contractor's network.

The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with community mental health centers, local health offices and prenatal clinics in order to promote health and wellness within its membership.

The Contractor shall have in place policies and procedures to ensure that materials distributed to members are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the member. The Contractor shall provide information requested by the State for use in member education, upon request.

4.4.1 New Member Materials

The Contractor has the option to provide to its DVHA members a Welcome Packet to introduce them to the ACO. If the Contractor chooses this option, the Welcome Packet is subject to review by DVHA to ensure consistency with other member materials sent out by DVHA. The Welcome Packet may include, but not be limited to, a new member letter, explanation of where to find information about the Contractor's provider network, information about completing a health needs screening and any unique features of the ACO.

The Contractor is required to give DVHA members the option to opt out of data sharing, that is, for DVHA to send the Contractor claims information about the member. A notice must be sent to attributed members outlining the procedures that the member may follow should they wish to change their claims data sharing preferences (either to opt in or opt out of data sharing).

4.4.2 Member Website

The Contractor shall provide and maintain a website for members to access information pertaining to the Contractor's services. The website shall be in a DVHA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. DVHA must approve the Contractor's website information. The website shall be accurate and current, culturally appropriate, and written for understanding at a sixth grade reading level. The Contractor shall inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention by the user to install plug-ins or additional software. The Contractor shall allow users print access to the information. Such website information shall include, at minimum, the following:

- Contractor shall provide, on its website, a link to DVHA's website so that members have access to a searchable online directory of participating Medicaid providers;
- The Contractor's contact information for member inquiries, grievances and appeals;
- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers;
- The member's rights and responsibilities, as enumerated in 42 CFR § 438.100, which relates to enrollee rights;
- A description of the Contractor's disease management programs and care management services;
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor;
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and
- Links to DVHA's website for general Medicaid information.

4.4.3 Preventive Care Information

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards.

4.4.4 Quality Information

Making quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor shall make quality information available to

members in order to facilitate more responsible use of health care services and inform health care decision-making.

Provider quality information shall also be made available to members. The Contractor shall capture quality information about its network providers, and must make this information available to members. In making the information available to members, the Contractor shall identify any limitations of the data. The Contractor shall also refer members to quality information compiled by credible external entities.

4.5 Member and Potential Member Communications Review and Approval

Member and potential member communications developed by the Contractor shall be approved by DVHA. The Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate DVHA's review and approval of member materials and document its receipt and approval of original and revised documents.

The Contractor shall not refer to or use DVHA or other state agency names or logos in its member and potential member communications without prior written approval. Any approval given for the DVHA or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

4.6 Member-Provider Communications

The Contractor shall comply with 42 CFR § 438.102, which relates to member-provider communications. The Contractor must not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under Medicaid or CHIP;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

4.7 Member Rights

Contractor's network shall adhere to the following Member's rights, in cooperation with DVHA:

- The right to receive information in accordance with 42 CFR § 438.10, which relates to informational materials;
- The right to be treated with respect and with due consideration for his or her dignity and privacy;
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

- The right to participate in decisions regarding his or her health care, including the right to refuse treatment;

- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and

- The right to be furnished health care services in accordance with 42 CFR § 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

Members shall be free to exercise protected member rights, and the Contractor shall not discriminate against a member that chooses to exercise his or her rights.

4.8 Interpretation Services

In accordance with 42 CFR § 438.10(c)(4), the Contractor shall arrange for interpretation services to its members free of charge for services it provides, including, but not limited to the member services helpline described in Section 4.3.1. The Contractor shall notify its members of the availability of these services and how to obtain them.

The requirement to provide interpretation applies to all non-English languages. Interpretation services shall include sign language interpretation services for the deaf.

Additionally, the Contractor shall ensure that its provider network arranges for interpretation services to members seeking healthcare-related services in a provider's service location. This includes that ensuring that providers who have twenty-four (24) hour access to healthcare services in their service locations (e.g. hospital emergency departments) shall provide members with twenty-four (24) hour oral interpreter services, either through in-person or telephonic interpreters. For example, the Contractor shall ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

For purposes of this section, the terms "the Contractor shall arrange for" and "the Contractor shall ensure" means that the Contractor's network shall fulfill those requirements.

4.9 Cultural Competency

In accordance with 42 CFR § 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

4.10 Advance Directives

The Contractor shall comply with the requirements of 42 CFR § 422.128, which relates to advance directives, for maintaining written policies and procedures for advance directives. The Contractor should adhere to Vermont State Law and the DVHA Provider Manual that addresses advance directives, which is excerpted below.

Hospitals, nursing homes, home health agencies, hospices and prepaid health care organizations are required to provide certain patients with information about their right to formulate advance directives and maintain written policies and procedures with respect to advance directives. They are also required to document in patients' files whether or not an advance directive is in effect, provide education for staff and the community on issues concerning advance directives, and ensure compliance with State law on advanced directives at their facilities. Providers are responsible to guard the confidentiality of member information in a matter consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law.

For purposes of this section, the terms "the Contractor shall comply with" and "the Contractor should adhere to" means that the Contractor's network shall fulfill those requirements.

4.11 Member Grievances and Appeals

DVHA shall maintain its own internal Grievance and Appeals. The Contractor, however, shall serve as the first line to intake grievances and appeals that are specific to actions taken by the Contractor related to its DVHA members. The Contractor shall establish written policies and procedures, subject to review and approval by DVHA, governing the resolution of grievances and appeals.

The Contractor shall be responsible for addressing the following situations whenever a member is attributed to the ACO:

- A member expresses dissatisfaction (a grievance) with the ACO, an ACO policy or a provider affiliated with the ACO; or
- A member wishes to appeal a decision or action taken by the ACO (in accordance with the definitions provided in 42 CFR § 438, Subpart F).

4.11.1 State Fair Hearing Process

In accordance with 42 CFR § 438.408, the State maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State.

If there is a reduction or termination in covered services in amount, duration or scope, then Medicaid recipients must have access to grievances, appeals and a state fair hearing process. In situations where an attributed ACO member has exhausted the Contractor's grievance and appeals process and is still dissatisfied, the member may request a DVHA fair hearing within ninety (90) calendar days from the date of the Contractor's decision. Although DVHA staff will coordinate the fair hearing process, the Contractor shall be responsible for providing all requested information made by DVHA related to the member appeal in the timeframe requested by the State. The Contractor shall assist DVHA, as needed and requested by DVHA, in support of the fair hearing process including, but not limited to, attending the fair hearing.

The Contractor shall include the DVHA fair hearing process as part of the written internal process for resolution of appeals.

4.11.2 Continuation of Benefits Pending Appeal

In certain member appeals, the Contractor will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR § 438.420. As a sub-delegated entity of DVHA,

the Contractor shall develop a policy to adhere to the requirements as described in 42 CFR § 438.420.

4.11.3 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The Contractor shall follow and communicate, when necessary, information listed in the DVHA General Provider Agreement related to member grievance, appeal and State fair hearing procedures and timeframes to providers and subcontractors at the time they enter a contract with the Contractor.

4.11.4 Recordkeeping Requirements of Grievances and Appeals

For purposes of quality review, the Contractor shall accurately maintain records for grievances and appeals that contain, at minimum, the following information:

- A general description of the reason for the appeal or grievance;
- The date the appeal or grievance was received;
- The date the appeal or grievance was reviewed;
- The resolution of the appeal or grievance;
- The date of the resolution of the appeal or grievance;
- The dates and details of all correspondence/communication between the Contractor and the member related to the grievance or appeal; and
- The name and UID number of the member for whom the appeal or grievance was filed.

The Contractor shall provide such record(s) of grievances and appeals monthly.

5.0 Provider Network and Services

5(A) With respect to Sections 5.1 to and including 5.2.5 below, the Parties agree that while OneCare has a network of providers to serve attributed members, OneCare does not limit attributed members to its network providers nor to services provided by network providers. The Parties further agree that attributed members may have care provided by any Medicaid provider in DVHA's network.

a. Based upon the assumption in Section 5(A), provider network composition requirements, DVHA's ability to require the expansion of the ACO network, the requirement of access reports, and specific requirements of durable medical equipment providers, chiropractors, physical and speech therapist providers and Non-Psychiatrist Mental Health and Substance Abuse Providers are removed from the Agreement.

b. The Parties agree that whether or not these aforementioned specialty providers exist in the OneCare contracted network, such services will be available to attributed members. Moreover, the Parties agree that as part of hospital service contracts many of these services may be provided in network through hospitals contracted with the ACO.

c. OneCare shall produce a geo-mapping report of its provider network in relationship to its attributed members. DVHA shall produce a geo-mapping of its provider network. The Parties shall work cooperatively to identify areas of improvement in provider networks and OneCare will cooperate with DVHA in efforts to improve access to cardiologists, primary care practitioners, and dermatologists.

5.1 Network Development

The Contractor shall develop and maintain a provider network in compliance with the terms of this section and 42 CFR § 438.206. The Contractor shall develop a network to meet the health care needs of its attributed population. The Contractor shall develop a comprehensive network prior to the effective date of the Contract. The Contractor shall be required during the readiness review process to demonstrate network adequacy through the submission of Geo Access reports in the manner and timeframe required by DVHA.

The Contractor shall ensure that its provider network:

- Provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members;
- Is geographically accessible; and
- Is supported by written provider agreements

The Contractor shall ensure that all of its contracted providers can respond to the cultural and linguistic needs of its attributed members. The network shall be able to meet the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

The Contractor shall ensure that all of its network providers are enrolled as Medicaid providers and follow all Vermont Medicaid provider enrollment criteria. In some cases, DVHA members attributed to the Contractor may receive covered services outside of the Contractor's provider network. The Contractor shall encourage providers outside of its network to enroll with both the Contractor and Vermont Medicaid.

The Contractor must monitor medical care standards to evaluate access to care and quality of services provided to members, evaluate providers regarding their practice patterns, and have a mechanism in place to address Quality of Care concerns.

5.2 Network Composition Requirements

DVHA will regularly and routinely monitor the Contractor's network access, availability and adequacy. DVHA may require corrective action if the Contractor fails to maintain a provider network commensurate with the number of attributed DVHA members.

At the beginning of its Contract with the State, the Contractor shall submit regular network access reports as directed by DVHA. The Contractor shall submit network access reports on an annual basis or at any time there is a significant change to the provider network e.g., the Contractor no longer meets the network access standards). The Contractor shall comply with the policies and procedures for network access reports set forth in ACO Reporting Manual. DVHA shall have the right to expand or revise the network requirements as it deems appropriate.

In accordance with 42 CFR § 438.12, the Contractor shall not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This does not require the Contractor to contract with providers beyond the number necessary to serve all of its members' needs. The Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with the Contractor's responsibilities.

The Contractor shall ensure that its network of providers adheres to requirements in the DVHA General Provider Agreement to offer hours of operation to DVHA members that are no less than the hours of operation offered to commercial members. The Contractor shall also make covered services available twenty four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the Contractor shall:

- Establish mechanisms to ensure compliance by providers;
- Monitor providers regularly to determine compliance; and
- Take corrective action if there is a failure to comply.

5.2.1 Acute Care Hospital Facilities

The Contractor shall provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected number of DVHA members. DVHA has set a goal for the Contractor that allows DVHA members to access hospital services within thirty (30) minutes in urban areas and sixty (60) minutes in rural areas. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care.

5.2.2 Primary Care Provider (PCP) Network Requirements

DVHA has set a goal for the Contractor that allows DVHA members access to PCPs within thirty (30) minutes of the member's residence, unless the attributed member has specifically selected a PCP that is outside of the 30-minute range. Providers that may serve as PCPs include:

- Family practitioners
- General practitioners
- Pediatricians
- Certified family practitioners
- Internal medicine physicians
- Geriatric medicine physicians
- Preventive medicine physicians
- Gynecologists
- Endocrinologists (if primarily engaged in internal medicine)
- Osteopathic medicine providers
- Naturopaths
- Nurse practitioners

The Contractor shall have a mechanism in place to track its PCPs' accepted Medicaid panel size. DVHA shall monitor the Contractor's PCP network to evaluate its member-to-PCP ratio.

The Contractor shall have a mechanism in place to ensure that contracted PCPs provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week and that PCPs have a mechanism in place to offer members direct contact with their PCP, or the PCP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PCP shall be available to see DVHA members at least three (3) days per week for a minimum of twenty (20) hours per week. The Contractor shall also assess the PCP's non-Medicaid practice to ensure that the PCP's Medicaid population is receiving accessible services on an equal basis with the PCP's non-Medicaid population.

The Contractor shall ensure that the PCPs serving as the ongoing source of the member's care provide "live voice" coverage after normal business hours. After-hour coverage for the PCP may include an answering service or a shared-call system with other medical providers.

5.2.3 Specialist and Ancillary Provider Network Requirements

The Contractor shall provide and maintain a comprehensive network of provider specialists and ancillary providers.

A physician contracted as a PCP with one ACO may contract as a specialist with other ACOs.

DVHA has set a goal for the Contractor to develop and maintain a comprehensive network of specialty providers listed below. For providers identified with an asterisk (*), the Contractor's goal is, at a minimum, two providers for each specialty type within sixty (60) minutes of the member's residence. For providers identified with two asterisks (**), the Contractor's goal is, at a minimum, one specialty provider within ninety (90) minutes of the member's residence.

Specialties	
➢ Anesthesiologists*	➢ OB-GYNs*
➢ Cardiologists*	➢ Occupational therapists*
➢ Cardiothoracic surgeons**	➢ Oncologists*
➢ Chiropractors**	➢ Ophthalmologists*
➢ Dermatologists**	➢ Orthopedic surgeons*
➢ Durable medical equipment providers*	➢ Orthopedists*
➢ Endocrinologists*	➢ Otolaryngologists*
➢ Gastroenterologists*	➢ Pathologists**
➢ General surgeons*	➢ Physical therapists*
➢ Hematologists*	➢ Psychiatrists*
➢ Home health care providers*	➢ Pulmonologists*
➢ Infectious disease specialists**	➢ Radiation oncologists**
➢ Interventional radiologists**	➢ Rheumatologists**
➢ Nephrologists*	➢ Speech therapists*
➢ Neurologists*	➢ Urologists*
➢ Neurosurgeons**	
➢ Non-hospital based anesthesiologist (e.g., pain medicine) **	

5.2.4 Non-psychiatrist Mental Health and Substance Abuse Providers

The Contractor shall establish a network of mental health providers, addressing both mental health and addiction, as set forth below.

The following list represents mental health providers that shall be available in the Contractor's network:

- Psychologists;
- Licensed Clinical Social Workers;
- Psychiatric Nurse Practitioners;
- Licensed Marital and Family Therapists;
- Licensed Mental Health Counselors;
- Licensed Alcohol and Drug Counselors;
- Board Certified Behavior Analysts; and

- Board Certified Assistant Behavior Analysts.

DVHA has set a goal for that Contractor that in urban areas, the Contractor shall provide at least one (1) mental health provider within thirty (30) minutes from the member's home. In rural areas, the Contractor's goal is to provide at least one (1) mental health provider within forty-five (45) minutes from the member's home. The Contractor must provide assertive outreach to members in rural areas where mental health services may be less available than in more urban areas. The Contractor also shall monitor utilization in rural and urban areas to assure equality of service access and availability.

All covered mental health services shall be delivered only by licensed providers within their scope of practice.

The Contractor is expected to coordinate with all county-based Designated Agencies (DAs), Special Service Agencies (SSAs) and Parent-Child Centers (PCCs). If all DAs, SSAs, and PCCs are not included in the provider network, the Contractor shall demonstrate that this does not hinder coordination of care or create an access issue. The Contractor shall, at a minimum, establish referral agreements and liaisons with DAs, SSAs, and PCCs.

5.2.5 [intentionally omitted]

5.2.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

DVHA strongly encourages the Contractor to contract with all willing Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that meet all of the Contractor's requirements regarding the ability of these providers to provide quality services.

5.2.7 School-based Services for Individualized Education Programs

DVHA strongly encourages the Contractor to develop relationships with providers of school-based services for children to ensure comprehensive multidisciplinary evaluation exists between the PCP and the school.

5.2.8 Urgent Care Clinics

DVHA strongly encourages the Contractor to affiliate or contract with non-traditional urgent care clinics, including retail clinics.

5.2.9 Other Providers

DVHA strongly encourages the Contractor to contract with other providers that deliver services covered in the capitation payment such as dialysis treatment centers, transplant centers, and transgender facilities.

5.3 Provider Contracting

The Contractor shall be responsible for assuring that its network providers are enrolled with Vermont Medicaid. DVHA will continue to enroll and revalidate providers using the Provider Screening and Enrollment requirements in 42 CFR § Subpart E. DVHA's enrollment criteria are outlined at http://www.vtmedicaid.com/Enrollment/enrollmentIndex.html#.

DVHA shall immediately disenroll any ACO provider if the provider becomes ineligible to participate in the Medicaid program for any reason. DVHA shall notify the Contractor at the time of disenrollment.

The Contractor shall immediately inform the DVHA Program Integrity Unit via a written communication should it disenroll, terminate or deny provider enrollment or credentialing for "program integrity" reasons (i.e., the detection and investigation of fraud and abuse).

The Contractor shall report the addition or disenrollment of any ACO-contracted provider on a weekly basis and indicate each provider's enrollment or termination effective date with the Contractor. Refer to Section 10.0 in this Attachment A for more details on this process.

5.4 Provider Agreements

The Contractor must have a process in place to review and authorize all network provider contracts. The network provider contracts must not be in conflict with any aspect of the DVHA General Provider Agreement.

DVHA has reviewed and approved OneCare network contracts.

The Contractor has submitted the complete list of providers who may be eligible to have attributed members.

The Contractor shall include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall identify and incorporate the applicable terms of its Contract with the State. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The provider agreements shall meet the following requirements:

- Describe a written provider claim dispute resolution process;
- Require each provider to maintain a current Vermont Medicaid provider agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board;
- Require providers to adhere to DVHA timely filing requirements for claims submissions.
- Include a termination clause stipulating that the Contractor shall terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or Vermont Medicaid provider agreement has terminated.
- Obligate the terminating provider to submit all claims or encounters for services rendered to the Contractor's members to DVHA's fiscal agent while serving as the Contractor's network provider.
- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.
- Provide a copy of a member's medical record at no charge upon request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.

For purposes of this section, OneCare agrees that its Network consists of Participating Providers as defined in Section 1.2.6 of Attachment A of this Agreement, which specifies that Participating Providers have a signed agreement with the ACO meeting the requirements of this Section 5.4.

5.5 [intentionally omitted]

5.6 Medical Records

The Contractor shall assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. The provider's medical record shall include, at a minimum:

- The identity of the individual to whom service was rendered;
- The identity of the provider rendering the service;
- The identity and position of the provider employee rendering the service, if applicable;
- The date on which the service was rendered;
- The diagnosis of the medical condition of the individual to whom service was rendered;
- A detailed statement describing services rendered;
- The location at which services were rendered;
- Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs; and
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment, must be attached to the prior authorization request and available for audit purposes.

The Contractor's providers shall maintain members' medical records in a detailed and comprehensive manner that conforms to the Office of Professional Licensing Standards, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records shall be legible, complete, signed and dated and maintained as per the DVHA General Provider Agreement.

Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including, but not limited to, 42 CFR § Part 2.

The Contractor's providers shall permit the Contractor and representatives of DVHA to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason. The failure of Contractor and/or its participating providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its participating providers repaying DVHA or Contractor for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not provided in a timely manner.

5.7 Provider Education and Outreach

The Contractor shall provide ongoing education about the ACO program as well as Contractor-specific policies and procedures to its provider network. In addition to developing its own provider education and outreach materials, the Contractor shall coordinate with DVHA-sponsored provider outreach activities upon request.

The Contractor shall educate its contracted providers, including mental health providers, regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud and abuse, pay-for-outcome programs and any other information relevant to improving the services provided to the Contractor's members.

5.7.1 Provider Communications Review and Approval

Provider communication materials specific to this contract shall be pre-approved by DVHA. The Contractor shall develop and include a Contractor-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a date issued or date revised clearly marked.

The Contractor shall submit all provider communication materials designed for distribution to, or use by, contracted providers to DVHA for review and approval at least thirty (30) calendar days prior to distribution. The Contractor must receive approval from DVHA prior to distribution or use of materials. DVHA's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon DVHA request.

The Contractor shall not refer to or use DVHA or other state agency names or logos in its provider communications without prior written approval by DVHA. Any approval given for the DVHA, or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

5.7.2 Provider Policy and Procedures Manual

The Contractor may provide and maintain a Provider Policies and Procedures Manual specific to Contractor operations provided that this manual is not in conflict with the information provided in the DVHA Provider Manual, found at:
http://www.vtmedicaid.com/Downloads/manuals/New%20Consolidated%20Manual/VTMedicaidProviderManual.pdf

If the Contractor develops an ACO Provider Policies and Procedures Manual, it shall be available both electronically and in hard copy (upon request) to all network providers, without cost, when they are initially enrolled, when there are any chances in policies and procedures, and upon a provider's request.

5.8 Contractor Outreach with Providers

The Contractor shall have in place policies and procedures to maintain frequent communications and provide information to its provider network. The Contractor shall give providers at least thirty (30) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The Contractor shall post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with 42 CFR § 438.102, the Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. Contractor shall communicate this clearly to all providers.

5.8.1 Provider Website

The Contractor shall maintain a provider website that contains information about its Medicaid line of business. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 4.4.2.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- DVHA's Provider Policy and Procedure Manual or a link to their website for same and any ACO Provider Policy and Procedure Manual and associated forms;
- Contractor's clinical guidelines;
- Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- Provider payment dispute resolution procedures;
- Appeal procedures;
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and
- Links to DVHA's website for general Medicaid information.5.8.2 Provider Services Helpline

In addition to the Provider Service Helpline provided by DVHA's fiscal agent, the Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints that are specific to ACO operations. The Contractor shall staff the Provider Services Helpline with personnel trained to accurately address provider issues from 8:00 am to 5:00 pm Eastern, Monday through Friday, at minimum. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours.

The ACO Provider Services Helpline may be closed on all holidays observed by the State government.

The Contractor must monitor its Provider Services Helpline and report its telephone service performance to DVHA each month as described in the ACO Reporting Manual, notwithstanding, OneCare may report member and provider hotline call statistics together.

5.8.3 State Fiscal Agent Workshops and Seminars

The State fiscal agent sponsors workshops and seminars for all Vermont Medicaid providers. The Contractor shall participate in the workshops and attend the provider seminars. A Contractor representative shall be available to make formal presentations and respond to questions during the scheduled time(s) as requested by DVHA. The Contractor is also

encouraged to set up an information booth with a representative available during the provider seminars.

5.9 Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions

The Contractor shall require that as a condition of payment, all providers agree to comply with the reporting requirements in 42 CFR § 447.26(d).

For purposes of this section, OneCare will support DVHA's payment policies and require providers to meet DVHA's reporting obligations and DVHA will create policies and procedures for said reporting. The Parties agree that under Attachment B of this Agreement, DVHA will regulate this function through its payment and review of claims.

5.10 Member Payment Liability

The Contractor and its subcontractors shall ensure that members are not held liable for any of the following:

- Covered services provided to the member which the Contractor is responsible for which the Contractor does not pay the provider; or
- The Contractor's debts or subcontractor's debts, in the event of the entity's insolvency.

The Contractor shall ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor. If the Contractor is aware that an out-of-network, non-Medicaid provider, such as an out-of-state emergency services provider, is balance billing a member, the Contractor shall instruct the provider to stop billing the member. The Contractor shall also contact the member to help resolve issues related to the billing.

Vermont Medicaid providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered Medicaid service.

6.0 Utilization Management

6.1 Utilization Management Program

OneCare agrees to perform utilization management of the services provided by network providers. However, because it receives an all-inclusive population-based payment, it has chosen not to require prior authorization of services that are included in the all-inclusive population-based payment for attributed members ordered by its network providers. DVHA will approve or disapprove utilization management policies provided by OneCare at the readiness review.

6.1.1 Clinical Guidelines

The Contractor shall establish and maintain medical management clinical criteria and practice guidelines in accordance with state and federal rules and regulations. Clinical criteria must be based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the Contractor's attributed members. The Contractor shall use a nationally recognized set of guidelines, including but not limited to McKesson Health Solutions' InterQual or Milliman Care Guidelines. If the Contractor chooses to utilize separate guidelines for physical health and mental health services, the Contractor shall demonstrate that the guidelines

are evidence-based and nationally recognized and that use of separate guidelines would have no negative impact on members, and would not otherwise violate the Contractor's requirements under 8 VSA§4089b.

For the 2017 Performance Year, DVHA and OneCare have mutually agreed that OneCare will use McKesson Health Solutions' InterQual® services ("McKesson") for Clinical Guidelines under section 6.1 of Attachment A, which contemplated the use of the McKesson service because it is a nationally recognized set of guidelines, and for reporting purposes. The reason McKesson was specifically referenced is because DVHA currently utilizes this same service for utilization management.

DVHA has purchased additional licenses from McKesson specifically for OneCare's use under the Vermont Medicaid Next Generation contract because OneCare agrees to reimburse DVHA for the price of these additionally purchased licenses. The purchase of these additional licenses is under DVHA's current contract with McKesson, DVHA Contract # 28176 (and subsequent amendments). DVHA shall invoice OneCare in the amount of $34,376.16 upon execution of this agreement, and OneCare shall have access to these licenses during the term of June 26, 2017 to December 9, 2017. OneCare agrees to the terms and conditions as set forth in DVHA Contract # 28176 (and all subsequent amendments) as applicable to their use of the licenses. OneCare agrees that it has no third-party beneficiary rights under DVHA Contract # 28176 (and subsequent amendments).

6.1.2 Practice Guidelines

The Contractor shall utilize practice guidelines that have been established by DVHA. The full list of guidelines is available at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines. The Contractor may adopt additional guidelines subject to the review and approval by DVHA.

Pursuant to 42 CFR § 438.210(b), relating to authorization of services, the Contractor shall consult with contracting health care professionals in developing practice guidelines. The Contractor shall, at a minimum, review and update the guidelines biannually, distribute the guidelines to providers and make the guidelines available to members upon request.

6.1.3 [intentionally omitted]

6.1.4 Utilization Management Policies and Procedures

The Contractor's utilization management program shall have policies and procedures that meet Vermont law. Additionally, the Contractor's policies and procedures shall comply with requirements in 42 CFR § 438.206 related to second opinions and women's health and 438.208 related to members with special health care needs direct access to a specialist.

The Contractor's utilization management program shall have policies and procedures that include appropriate timeframes for:

- Completing provider and member appeals and expedited appeals for determinations of medical necessity, per state law; and
- Notifying providers and members of the Contractor's decisions on appeals and expedited appeals determinations of medical necessity.

The Contractor's utilization management program shall have policies and procedures and systems in place to assist utilization management staff in:

- Identifying instances of over- and under-utilization of emergency room services and other health care services,
- Identifying aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams),
- Ensuring active participation of a utilization review committee,
- Evaluating efficiency and appropriateness of service delivery,
- Incorporating subcontractor's performance data (if any function is subcontracted), and
- Facilitating program management and long-term quality of care and identifying critical quality of care issues.

The Contractor's utilization management program shall not be limited to traditional utilization management activities. The Contractor shall maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management/Assurance and Improvement Program as described in Section 8 of this Attachment A.

The Contractor's utilization management program shall refer members to care coordination and disease management, care management and case management, as set forth in Section 7 of this Attachment A. The Contractor's utilization management program shall also encourage and educate members on health literacy and informed, responsible medical decision making.

The Contractor shall identify areas of high and low utilization and key reasons for the utilization patterns. The Contractor shall identify those members that have over- or under-utilization and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, care management or complex case management services.

In order to monitor potential under- or over-utilization of mental health services, DVHA may require the Contractor to provide separate utilization reports for mental health services.

6.1.5 [intentionally omitted]

6.1.6 [intentionally omitted]

6.1.7 [intentionally omitted]

6.2 Utilization Management Oversight

The Contractor will maintain policies and practices that support regular and ongoing monitoring of under- and over- utilization, identification of trends, and the identification and implementation of changes in policies, processes, and practices. The Contractor will meet with the DVHA Medical Director and/or designees at least biannually to review utilization trends among ACO attributed and non-ACO attributed members.

6.3 Blueprint for Health Data

DVHA agrees to provide Blueprint for Health clinical registry (or Vermont Clinical Registry) data regarding provider practice metrics to assist OneCare in assessing practice management for both healthcare utilization and care management. The frequency of data distribution will be based on the Parties' agreement.

7.0 Care Management

The Contractor's primary function in support of its DVHA members is to integrate and enhance the coordination and management of care of members.

The Contractor shall develop policies and procedures regarding physical and mental health coordination. Further, the Contractor should be prepared to monitor and evaluate the effectiveness of its policies and procedures and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes.

The Vermont Chronic Care Initiative (VCCI) program at DVHA will remain actively involved in complex case management for the population of non-ACO attributed Medicaid members who meet the pre-defined eligibility requirements of the program. At the initiation of this contract, it is anticipated that some members currently receiving complex case management through the DVHA VCCI program will attribute to the ACO and be care managed by the ACO. DVHA will provide the list of these members to the ACO. The Contractor must begin active engagement with these members immediately upon notice of attribution.

At the time that members attribute to the ACO, DVHA members may already be receiving case management from another entity such as a Designated Agency. As such, the Contractor will work with the member and the other entity (if it is a participating or an aligned entity with which protected health information is allowed to be shared) to determine where and how the member should receive case management services across organizations.

OneCare agrees to provide policies and procedures regarding care management to be reviewed at the readiness review by DVHA.

OneCare agrees to use the Johns Hopkins ACG System as suggested in Section 7.2 of this Attachment A to perform the required risk stratification of attributed members. OneCare agrees that while risk stratification modeling is performed electronically and some portions of care management are performed through the use of the telephone via synchronous and asynchronous methods (e.g., phone, video, email, letters), it will employ licensed staff as stated in Section 7.2 of this Attachment A. OneCare agrees to employ health professionals for beneficiary contact (person to person) to effectuate care management services, other than as set forth in Section 7.2.3 below.

For the purposes of this section, any clinical assessments or screenings conducted directly with attributed members will be performed by the Contractor's network of providers. The Parties agree that OneCare does not directly deliver services or conduct clinical assessments, but does so through its contracted network.

7.1 Member Assessment

7.1.1 Initial Screening

An initial screening is conducted within ninety (90) calendar days of contract initiation for each DVHA member who has not been seen by a primary care provider (PCP) within the previous 12 months to identify the member's immediate physical and/or mental health care needs. The initial screening will identify members who have complex or serious medical conditions as well as those who are receiving ongoing treatment. This screening must consider screening for conditions such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD), Hypertension and Asthma. Additionally, the Contractor will identify those members who are due (or overdue) for their recommended Preventive Health Evaluations. The initial screening will also assist in determining if the member should be included in the Care Management Program.

The Contractor's initial screening tool(s) shall be evidence-based, shall align with other State screening tools, and will be subject to DVHA's review prior to use. The results of the screening may trigger supplemental questions or could require immediate triage and referral to a licensed health care professional per clinical protocols developed by the Contractor.

The initial screening may be administered in person, by phone, electronically through the Contractor's secure website, or by mail to assure the engagement of the largest number of members. The Contractor must provide information on the number of members screened in this process.

7.1.2 Comprehensive Health Assessment

For individuals stratified into the medium or high risk care management levels, the Contractor will complete an evidence-based Comprehensive Health Assessment within 180 days of attribution to the ACO. The Comprehensive Health Assessment will be used to develop and implement a comprehensive care plan to meet the member's needs as well as personal health goals. The Contractor may utilize different Comprehensive Health Assessments for children, adolescents, and adults.

The completed comprehensive health assessment should be shared with the member's PCP and/or mental health providers with appropriate consents and permissions. The Contractor shall develop a solution for storing the information collected from comprehensive health assessments in a standard electronic format and in a manner that can be shared with health professionals and DVHA.

7.1.3 Screening and Assessment of Women of Child Bearing Years

The Contractor shall implement methods to promptly identify members who are of child bearing years to assess pregnancy plans. DVHA strongly encourages that, in order to be consistent with other state assessment tools, the Contractor includes as part of this screening the State's one key question, "Would you like to become pregnant in the next year?" and, based on the member's response, a related follow up plan for risk prevention.

All identified pregnant women shall have a comprehensive health assessment completed. Any pregnancy risk assessment tools must include pregnancy risk factors such as prior history of pre-term labor, multiple births, use of alcohol or controlled substances, obesity, smoking, or other indicators which put both mother and infant at risk.

7.1.4 Other Screenings

In addition to the Comprehensive Health Assessment, the Contractor should use other strategies to identify the risk and needs of its members. Other strategies may include, but are not limited to:

- Analyze claims and medical records to assess diagnoses;
- Identify gaps in care;
- Gather any information from previous care plans, when available; and
- Review information with the member to identify the member's care strengths, needs and available resources to enable person-centered planning. This will include family and caregiver input, as appropriate.

7.2 Risk Stratification

The Johns Hopkins ACG System will be used to supplement the initial screening and other tools proposed by the Contractor to aid in the stratification of members into appropriate care management levels based on severity and risk scores. The predictive modeling tool will assign members to one of four Care Management Levels listed below:

- Low Risk – Members with low risk are assigned to "Healthy Member" Level of Care.
- Medium Risk – Members with medium risk are assigned to "Disease Management" Level of Care.
- High Risk – Members with high risk are assigned to "Care Coordination" Level of Care.
- Very High Risk – Members with very high risk are assigned to "Complex Case Management" Level of Care.

The requirements for members assigned to each Care Management level are described below:

7.2.1 Low Risk

Description: Intended for members with no disease indicators and no risk identified.

Interventions: Contractor is encouraged to develop interventions that support continued healthy behaviors.

7.2.2 Medium Risk

Description: Intended for members with, or at risk for, a chronic condition such as CHF, COPD, Diabetes, CAD, Hypertension or Asthma.

Interventions: Contractor is encouraged to focus on interventions such as:

- Distribution of educational materials
- Preventive Care reminders

- Referrals to evidence-based self-management services to support sustainable changes via improved skill and confidence.
- In addition to all services listed above, pregnant women also receive the following interventions:
    - Pregnancy care health education materials
    - Tobacco cessation materials
    - Other services specific to their pregnancy risk factors

Method of Communication: US mail, electronic direct-to-consumer contacts, interactive voice recordings, and/or web-based education materials

Frequency of Communications: Minimally two times per year

Qualifications of Staff: Health coaching services may be provided by non-clinical staff as appropriate with escalation to licensed clinical staff as indicated by educational need, provider request and/or change in clinical status.

7.2.3 High Risk

Description: Intended for members who need assistance with care coordination, making preventive care appointments, and accessing care to address the member's chronic health conditions and supporting adherence to treatment plan. This level may also include assistance with obtaining needed social services to address the member's ongoing health needs. Members who are at risk for an acute or catastrophic episode in the future may be prioritized for high risk level of care management services (Complex Case Management).

Interventions: Contractor is encouraged to focus on interventions such as:

- All interventions described in 7.2.2 above
- Comprehensive health assessment
- Prioritized problem list and related goals regarding patient self-management
- Coordination among service providers
- Assistance with appointments
- Education regarding the following:
    - Diagnosis
    - Prescribed treatment and importance of adherence to treatment
    - Use of medical home
    - Appropriate use of urgent and emergent care services
    - Self-management skills and plan specific to diagnosis

Method of Communication: Telephonic or in-person

Frequency of Communication: Four times per year

Qualification of Staff: Licensed staff with experience and training in care management and/or complex case management. Health coaching services may be provided by non-clinical staff as appropriate with escalation to licensed clinical staff as indicated by educational need, provider request and/or change in clinical status.

7.2.4 Very High Risk

Description: Involves the active coordination of care and services with the member and among providers while navigating the extensive systems and resources required for the member. It includes the implementation of a complex case management plan directed at the member's chronic health conditions. Within the plan, targeted and achievable goals will be set by the Contractor with the active participation of the member. Goals may also be psychosocial in nature if they take priority for ensuring the improvement of the member's health condition. Goals must have defined milestones to document progress, clearly defined accountability and responsibility, and timely review with appropriate corrections as indicated. Members who are stratified as high risk may exhibit one or more of these conditions:

- Multiple chronic conditions
- High service utilization patterns
- High and complex pharmacy utilization
- Cognitive involvement
- Psychosocial or socioeconomic indicators of health

Interventions: Contractor is encouraged to focus on interventions such as:

- All interventions described in 7.2.3 above
- Development of a comprehensive care plan directed at the member's chronic health condition (described in 7.3 below)
- Coordination and sharing of information on interventions and treatments among providers, particularly between physical health and mental health providers

Method of Communication: Telephonic or in-person

Frequency of Communication: As condition requires, minimally monthly. Case managers should be able to engage in care conferences with the member's health care providers as necessary.

Qualification of Staff:

- The Contractor's staff performing complex case management must be licensed physician assistants, registered nurses, therapists, social workers, mental health providers, and/or licensed alcohol and drug counselors (LADCs).
- Complex case management staff must have the training, expertise and experience in providing case management and care coordination services for individuals with complex health needs, including individuals with mental health needs.
- The active member-to-staff ratio will not exceed 50:1.

7.3 Care Plan Development

For individuals participating in complex case management, the Contractor shall utilize a person-centered care plan development process which is evidence-based. The Contractor will use data from multiple sources in the development of each member's care plan including, at minimum, claims data, data collected through the predictive modeling tool, the initial health screening, the comprehensive health assessment, available medical records, bio-medical data, and consultations with the member's health care providers which should occur at least every other month.

Services called for in the care plan will be coordinated by the Contractor's care management staff, in consultation with any other care managers already assigned to a member by another entity.

Contractors shall initiate mechanisms for members, their families and/or advocates, or others chosen by the member to be actively involved in the care plan development. The member or family should become knowledgeable about the care plan, such as an understanding of care plan goals and medication names, their uses and side effects.
The care plan must reflect cultural considerations of the member including the Contractor's strategies to engage with members with limited English proficiency.

The Contractor's Medical Director shall be available to consult with the clinicians on the complex case management team as needed to develop the care plans for high risk cases and consult with the DVHA Medical Director as appropriate.

The care plan must be adjusted to meet individual needs and may include elements such as those listed below:

- Clinical history
- Diagnosis
- Functional and/or cognitive status;
- Immediate service needs;
- Use of services not covered by the ACO;
- Accommodation needs;
- Barriers to care (e.g., language, transportation);
- Names of the member's health care providers;
- Local community resources;
- Family or other natural support resources;
- Clearly identified, member-centered, measurable long-term goals and objectives;
- Clearly identified, member-centered, measurable short-term goals and objectives;
- Goals and planned interventions and progress toward goal achievement including objective measures as biomedical data (e.g., HEDIS measures);
- Utilization statistics on hospitalizations, emergency services, primary care and specialty care;
- Self-management status/referral;
- Readiness for change and engagement level; and
- All contacts with the member, his/her providers and other service delivery entities.

The Contractor will develop a process for reviewing and updating the care plans with members on an as-needed basis, no less often than annually. In addition, the Contractor shall develop a protocol for re-evaluating members who have moved across the levels of management (disease, care and complex case management). The Contractor shall identify triggers which would immediately move the member to a more assistive level of service.

7.4 Reporting Requirements

The Contractor shall document the number of members participating in care management by care management level and by condition of interest at intervals specified by DVHA.

The Contractor shall be prepared to report on the interventions utilized in each care management level and the success rate of these interventions.

The Contractor shall document case management contacts, interventions and outcomes in an electronic care management system. A monthly electronic file of key variables in the care plan of each DVHA attributed member as high risk shall be made available to the DVHA case management system via an electronic interface in a file format approved by DVHA to support a single continuous care plan in the event that a DVHA member transitions into or out of the ACO over the course of the contract. Refer to Section 10.4.9 in this Attachment A for more details on this file exchange.

7.5 Payment for administrative activities related to Health Information Technology (Section E.6.b of Attachment B)

This section pertains to the creation and distribution of new tools and the development of existing tools to enhance OneCare's existing population health management analytics and care coordination platform by adding new analytic applications and system functionality, along with providing technical assistance and deployment support to ACO providers throughout the OneCare network.

The data obtained will be used to support effective population health management under the Vermont Medicaid Next Generation program and the All Payer ACO Model.
The provider populations that are targeted for this project span the entire continuum of care, from tertiary care, community, and critical access hospitals, primary and specialty care physicians, home health, skilled nursing facilities, mental health agencies, and community support agencies that collaborate with OneCare.

Goal 1: WorkbenchOne (WBO) and Care Navigator
Goal 1 related to Section 7.5 is to customize and enhance the functionality of WorkbenchOne (WBO) and Care Navigator, and customize analytic applications as needed for all ACO payer programs in order to leverage existing capabilities and operate under a common model to support Vermont providers.

To achieve Goal 1 for Section 7.5 in Quarters 3 and 4 (7/1/17 – 12/31/17), the Contractor shall:

1. Create an application to monitor utilization of services and identify trends of over- or under-utilization where intervention may be indicated
2. Create an application for risk bearing providers to monitor financial goals against contract targets
3. Create an All Payer Model Quality Measure scorecard report, to ensure ongoing monitoring of quality measure performance throughout the year
4. Integrate inpatient and emergency room event notification into Care Navigator in order to support complex care coordination
5. Develop a Care Coordination Effectiveness & Outcomes Analysis framework to monitor program effectiveness and inform program changes or enhancements
6. Analyze Clinical Data Quality Reporting, to identify the areas where clinical data from source systems or VITL are not available to perform automated quality measurement

Payment for achievement of Goal 1 for Section 7.5 in Quarter 3 (7/1/17 – 9/30/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than October 15, 2017, provide the following to DVHA:

- Examples of all reports derived from the applications above (Goal 1, items 1-3)
- Minutes of Utilization Review Committee meetings where utilization data and trends are reviewed and action plans are developed as appropriate
- Login credentials to DVHA clinical and analytics staff to allow for access to the utilization application for the VMNG population
- A list of users of the financial application above (Goal 1, item 2)

Payment for achievement of Goal 1 for Section 7.5 in Quarter 4 (10/1/17 - 12/31/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than January 15, 2018, provide the following to DVHA:

- Demonstration of the event notification functionality within Care Navigator (Goal 1, item 4)
- Template for the Care Coordination Effectiveness and Outcome Analysis framework (Goal 1, item 5)
- Written report summarizing the results of the Clinical Data Quality analysis (Goal 1, item 6)

Goal 2: Training and Technical Assistance on Advanced Analytics
Goal 2 related to Section 7.5 is to provide training and technical assistance on new advanced analytic applications, dashboards, and reports to network participants in order to support provider lead health care reform efforts goals under the All Payer ACO Model.

To achieve Goal 2 for Section 7.5, in Quarters 3 and 4 (7/1/17 – 12/31/17), the Contractor shall:

1. Provide training and technical assistance to the network on the interpretation of under/over utilization trends and financial trends against targets
2. Provide training and technical assistance to the network on quality measures and performance against targets (based on available claims data)
3. Develop training materials/workflows for care coordinators in the use of event notification

Payment for achievement of Goal 2 for Section 7.5 in Quarter 3 (7/1/17 – 9/30/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than October 15, 2017, provide the following to DVHA:

- Summary to DVHA on how these applications are being utilized by the network at large and by OneCare committees
- Listing of the network participants that have received training and technical assistance during Q3

Payment for achievement of Goal 2 for Section 7.5 in Quarter 4 (10/1/17 - 12/31/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than January 15, 2018, provide the following to DVHA:

- Summary on how these reports are being utilized by the network at large and OneCare committees
- Materials/workflows for event notification use
- Listing of the network participants that have received training and technical assistance during Q4

Funding for activities in support of Section 7.5, Goals 1 and 2, shall be distributed as two equal,

quarterly payments upon DVHA's receipt and approval of the deliverables described above. If OneCare is unable to submit the documentation by the delivery date by no fault of its own, OneCare and DVHA will work together to identify a mutually agreeable delivery date based on the circumstances. If OneCare is unable to submit the documentation by the extended delivery date, OneCare will forfeit the payable amount associated with both Goals in that quarter.

7.6 Payment for administrative activities related to Advanced Community Care Coordination (A3C) (Attachment E.6.c of Attachment B)

This section pertains to the development of a team-based approach to care coordination designed to strengthen relationships between primary care and the continuum of care providers. OneCare shall develop a financial and clinical model that promotes an integrated team based system of care coordination consistent with its intellectual properties and health information technology rights. This shall include involvement from local integrated care teams (e.g. PCMH and Continuum of Care Providers) that support the physical, mental, and social wellbeing of attributed populations. The objective is to achieve care that is person centered, efficient and equitable. One approach to an integrated model of care will be the use of Advanced Community Care Coordination (A3C) in risk communities.

The populations that are targeted for this project include the top 16% of Medicaid members that are attributed to OneCare. The top 16% includes DVHA's high and very high risk members and are identified through predictive modeling software using the John's Hopkins Adjusted Clinical Groups (JH ACG) to stratify and identify specific populations with complex needs. Care team members can retrieve this information from OneCare's Care Coordination Software (Care Navigator) in order to support them in prioritizing individuals that need outreach.

Goal 1: Support Effective Team Based Care Coordination at the Local Level
Goal 1 related to Section 7.6 is to initially work with providers enrolled in the VMNG program to develop and refine a team based care model for care coordination that supports populations with complex needs, with the ultimate goal of developing a model that can be scaled statewide to all willing participants.

To achieve Goal 1 for Section 7.6, in Quarters 3 and 4 (7/1/17 – 12/31/17), the Contractor shall, for enrolled VMNG providers:

1. Develop and refine team based care coordination protocols between primary care medical home (PCMH) and continuum of care providers
2. Provide training and technical assistance on risk stratification and care coordination core competencies that support person centered care
3. Provide training on expectations for team-based care-coordination, and support in the use of Care Navigator to complete person-centered shared care plans
4. Develop and deploy care coordination best practices and lessons learned across current VMNG communities via monthly cross-community care coordination team meetings
5. Evaluate, and refine if necessary, care coordination protocols to support the care model
6. Develop a plan to evaluate existing care coordination competencies and address identified gaps in local knowledge and/or skill
7. Measure consistent use of shared care plans across sites
8. Convene PCMH staff, Blueprint for Health staff and community agencies, representing the continuum of care, to make recommendations on how to refine the care model in order to allow it to be sustainable with population growth
9. Develop a planning roadmap for expansion to additional populations

10. Provide community capacity payment in each risk-based community in partnership with the Blueprint for Health
11. Provide ongoing PMPM to primary care, home health, designated agencies and area agencies on aging for engaging in a team-based approach to coordinating care

Payment for achievement of Goal 1 for Section 7.6 in Quarter 3 (7/1/17 – 9/30/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than October 15, 2017, provide to DVHA:

- Examples of policies and/or protocols of team based care workflows.
- Summaries of the trainings that have occurred on risk stratification and care plans
- Summaries of trainings that have occurred to educate network participants on expectations for team-based care coordination
- Copies of agendas and materials from monthly cross-community care coordination team meetings to facilitate dissemination of best practices and lessons learned

Payment for achievement of Goal 1 for Section 7.6 in Quarter 4 (10/1/17 - 12/31/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than January 15, 2018, provide to DVHA:

- Summaries of modifications made to workflows and recommendations for improvements
- A plan to enhance care coordination competencies in local communities in 2018
- Report quantifying the number of shared care plans across sites
- Roadmap for expansion of OneCare's care coordination model to additional populations
- Summary of lessons learned and recommendations for future improvements

Goal 2: Develop a framework that will capture the value/impact of care coordination activities Goal 2 related to section 7.6 is to identify key metrics and a framework to evaluate value of care coordination impact over time for the defined populations. The framework would be designed to support current and future model development, while remaining flexible so that it may be adapted as the program matures.

To achieve Goal 2 for Section 7.6, in Quarters 3 and 4 (7/1/17 – 12/31/17), the Contractor shall:

1. Establish work groups across sites designed to support development and adoption of framework
2. Provide for ongoing PMPM to one lead care coordinator activating and engaging attributed members in a shared care plan
3. Provide for a one-time payment annually to one lead care coordinator for activating and engaging attributed members in a shared care plan
4. Identify key metrics to track the value/impact at the systems and local level
5. Build a dashboard in Care Navigator to display key metrics that will be evaluated on an ongoing basis
6. Evaluate data to identify early indicators of success

Payment for achievement of Goal 2 for Section 7.6 in Quarter 3 (7/1/17 – 9/30/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than October 15, 2017, provide to DVHA:

- Summary of research and recommendations of workgroups on key outcome metrics that will be used to evaluate the impact/ value of the program

- Documentation of the number of one-time and PMPM payments distributed to providers in Quarter 3

Payment for achievement of Goal 2 for Section 7.6 in Quarter 4 (10/1/17 – 12/31/17) shall be contingent upon the Contractor's submission and DVHA's approval of the following deliverables. The Contractor shall, no later than January 15, 2018, provide to DVHA:

- Report that evaluates key metrics using the first quarter program data
- Care Navigator dashboard access for a DVHA user, or Care Navigator reports displaying key metrics included in new dashboard
- Documentation of the number of one-time and PMPM payments distributed to providers in Quarter 4

Funding for activities in support of Section 7.6, Goals 1 and 2, shall be distributed as two variable quarterly payments upon DVHA's receipt and approval of the deliverables described above, and based on documentation in the contractor's invoices of the number of one-time and PMPM payments distributed to providers in each quarter. If OneCare is unable to submit the documentation by the delivery date by no fault of its own, OneCare and DVHA will work together to identify a mutually agreeable delivery date based on the circumstances. If OneCare is unable to submit the documentation by the extended delivery date, OneCare will forfeit the payable amount associated with the Goal(s) for which documentation was not submitted on time.

8.0 Quality Management

The Parties hereby agree it is their intention and mutual understanding that the program described below in Section 8.0(A), together with the requirements of Section 2.0 of this Attachment A, if properly and completely carried out by OneCare, are sufficient to fulfill the requirements of the entirety of Section 8.0 of this Attachment A as set forth below.

8.0(A) OneCare's Quality Improvement Program Approach

OneCare deploys a robust quality improvement (QI) program that permeates all aspects of our ACO including our clinical activities and our administrative processes and programs. The quality program utilizes a two-part framework developed by Langley et al consisting of *The Model for Improvement* together with Plan-Do-Study-Act (PDSA) cycles. The Model for Improvement provides improvement teams with three critical questions that guide and inform the development, execution, and evaluation of their QI projects. It asks:

- "What are you trying to accomplish?"- to guide teams in the creation of clearly defined project aim statements;
- "How will you know a change is an improvement?"- to guide teams in creating robust measures to assess change; and
- "What changes can you make that will result in improvement?" - to prompt the generation of new ideas and identification of existing primary drivers and evidence-based interventions that can be tested at a small scale to inform improvement efforts.

In a complementary fashion, once key interventions are identified and prioritized, PDSA cycles are used to test them in rapid sequence to identify which changes add value and improve the processes and outcomes of care. The PDSA approach is a widely demonstrated, simple but powerful, tool for implementing quality improvement. While most QI projects are amenable to this approach, OneCare will call upon other QI frameworks and methods as appropriate to address specific gaps in care. For example, we may use LEAN

methodology to promote value-stream mapping and identify waste within the system, the NIATx behavioral health improvement model with its focus on understanding the voice of the customer in improving access to and retention in treatment programs, or cost effectiveness analysis when multiple interventions are identified and the case for which intervention is preferred is not clear.

OneCare's clinical quality improvement model recognizes three fundamental processes to improve health, experience of care, and control costs (Figure 14). It is predicated on regular assessment of quality metrics, including measures defined by the payers as well as those identified by OneCare's clinical governance and leadership team, and measures requested from network participants. These metrics are analyzed and reported on at regular intervals (monthly, quarterly, annually) as defined by the measure specifications, availability of data, and intended use. Historically data reports have been generated solely by OneCare's data informatics and analytics team, however, the upcoming deployment of a new informatics platform, Health Catalyst, will supplement the work of the data and analytics team providing OneCare clinical leadership as well as permissioned network participants with real time point of service access to data to guide and inform decision-making. Using these reports, the Clinical Advisory Board reviews the ACO's performance, identifies gaps and opportunities for improvement and recommends a set of clinical priority areas each year. These clinical priority areas typically align with selected payer quality measures; however, additional priorities are considered if they are identified to be high leverage opportunities to address unwarranted variation, under/over utilization of services, or opportunities to improve patient outcomes and/or reduce health care expenditures while maintaining or improving quality of care. Once established, these clinical priority areas are broadly disseminated by OneCare's clinical and quality improvement team and our Regional Clinical Representatives (RCR). In this way, clinical priority areas agreed upon across the network are spread to the Community Collaboratives and to specific facilities (i.e. hospitals, specialty and primary care practices, community service agencies) to serve as the focus of quality improvement (QI) initiatives. The RCRs report out on the progress of these QI projects at regular intervals through OneCare's clinical governance structure (described below).

Figure 14: OneCare's Clinical Quality Improvement Model

In order to support a culture of continuous quality improvement across our ACO network, OneCare supports three foundational components in its quality program:

1. Clinical and Quality Improvement Governance and Management
2. Advanced, Timely, and Highly-Reliable Data Analytics
3. Resources, Education and Training on Quality Improvement

Each of these approaches is described in detail below.

1. Clinical and Quality Improvement Governance and Management: The combination of OneCare's statewide reach and full continuum of care providers under a collaborative governance and network model has provided for a strong population health management platform able to meet the Triple Aim for a population of over 100,000 lives. OneCare has designed a structure that allows participants significant input and a strong voice in governance and establishing the clinical and quality programs that form the basis for a result oriented statewide network. In brief, our governance model begins with a Board of Managers (BOM) that maintains overall responsibility for our care model as well as for monitoring participant compliance and our actual clinical performance and costs (see bidder capacity for additional information). The BOM delegates operationalization of these tasks to several subcommittees including a Population Health (PH) Strategy Subcommittee, a Clinical Advisory Board (CAB), a Quality Improvement Committee (QIC) and a Pediatric Subcommittee, among others.

   - The PH Strategy Subcommittee assures there is a strategy in place to deliver on OneCare's population health management care model, including clinical integration, quality assurance, and data-driven programs. The PH Strategy Subcommittee is informed by other OneCare committees and its management team. The PH Strategy Subcommittee makes recommendations to the BOM to ensure that the population health strategy and operations enable OneCare's objective of establishing a health care delivery system capable of taking accountability across the entire population of attributed lives. The PH Strategy Subcommittee therefore has responsibility for overseeing and updating the PHM care model, providing input into and monitoring the success of OneCare's clinical priorities and strategies, establishing initiatives to address social determinants of health and underlying community and patient needs, overseeing quality, cost, and patient experience across the ACO, recommending resource allocation to the BOM Finance Committee in order to implement OneCare's clinical strategy, and providing guidance and strategy related to data transparency and sharing across the network.

   - The Clinical Advisory Board (CAB) is responsible for developing and implementing a clinical and community based integrated care model designed to achieve high quality, coordinated care, and efficient health care delivery across the population. The CAB is responsible for promoting evidence-based medicine and clinical guidelines, prioritizing network resources toward specific clinical and community improvement projects, fostering activities that increase patient engagement and promote patient-centered care, and endorsing and developing common tools, processes, and operations to optimize execution of OneCare's care model.

   - The Quality Improvement Committee (QIC) consists of network participants and health care quality experts, is chaired by OneCare's Chief Medical Officer, and attended by OneCare leadership and management staff. It is charged with overseeing the quality of care provided by the network. The QIC uses data-driven methods to identify new opportunities for quality assurance and improvement and measures the results of implemented programs. It is responsible for:

- reviewing initial and ongoing data reports of local and statewide participant utilization, expenditure, and quality performance
- serving as the starting point for quality improvement, measurement, and assurance activities
- monitoring and approving OneCare's quality improvement strategy and work plan
- promoting strategies to improve access to care and services
- overseeing the quality measures collection and reporting process
- optimizing patient engagement and identifying and supporting strategies to improve patient experience of care
- supporting the work of the Community Collaboratives by sharing best practices in quality improvement and evidence-based care

The QIC also serves as the major forum for sharing quality improvement priorities between the major insurers, hospital organizations, independent physician organizations, primary care organizations, community service provider organizations, and state agencies to ensure that clinical priorities are unified to the fullest extent possible.

- OneCare's Pediatric Subcommittee consists of pediatric providers from the ACO and affiliated community partners; it is charged with guiding and developing recommendations for network-wide policy concerning the care of pediatric patients. The Pediatric Subcommittee initiates programs and policies around pediatric care including measures, quality improvement, health and wellness efforts, and pediatric care coordination.

To operationalize the work of the BOM and its committees, OneCare draws upon its highly trained workforce that has expertise in population health management, quality improvement, care management and care coordination, community facilitation and team building, health care delivery systems, computer information systems, data analytics including advanced statistical analysis, and technical and operations support (see bidder capacity for detailed descriptions of this workforce).

OneCare has amassed and retained the state's largest value-based care network of hospitals, physicians and other clinicians who have worked collaboratively with the Blueprint for Health and the other two ACOs to improve the quality of care of Vermonters. In 2015, in collaboration with the Blueprint for Health and the other ACOs, OneCare implemented a strategy to engage community-wide health and social services providers across the continuum of care to increase our collective impact through the organization and support of Community Collaboratives (also known as Regional Clinical Performance Committees or Unified Community Collaboratives). These Community Collaboratives are tasked with taking a population-wide view of health and wellbeing for all citizens in their designated health service area and identifying areas of opportunity as well as strengths to be fostered. OneCare recognizes that each Community Collaborative may face issues unique to their community, issues which affect the overall health of the population they serve. It is therefore important that, with the support of OneCare data and local community input, each of the Community Collaboratives will have the opportunity through a needs assessment or other defined process to identify additional quality initiatives, beyond the ACO clinical priority areas, that best serve the needs of their community. To support the work of the Community Collaboratives, OneCare provides each community with access to regional performance data and benchmarks, clinical change packets, evidence-based care pathways, care coordination supports, and staffing resources coordinated with Blueprint leadership to support the local systems of care to achieve the Triple Aim. Further, OneCare provides staffing support in each health service area in the form of assigned OneCare Clinical Consultants and Regional Clinical Representatives (RCR) who are contracted

local physician and/or advanced practice providers responsible for serving as a local convener and chair or co-chair the Community Collaboratives. OneCare also has a dedicated data informatics and analytics team to produce analysis specific to their business needs. Together the Clinical Consultants, the data informatics and analytics team and RCRs, facilitate the local and regional clinical quality priorities.

2. Advanced, Timely, and Highly-Reliable Data Analytics: OneCare participants cannot identify high-leverage opportunities to improve health care delivery and health outcomes if they do not have access to high-quality, timely, reliable, and sensitive data to inform and guide: a) an assessment of baseline performance, b) identification of benchmarks, c) stratification of data to examine underlying patterns of variation, and d) small, rapid cycle tests of change. Thus, OneCare has invested significant resources in developing a robust data analytics and informatics platform. As a result, OneCare's analytics team is able to provide network participants with specific data to measure the effectiveness and quality of their care delivery and associated health outcomes. These data reports range from patient-level identification of outliers (i.e. special cause variation) to systematic assessment of clinical, utilization, and cost data across the ACO, among health service areas (HSAs), within facilities, including drilling down to the level of individual providers. These comprehensive analyses provide participants with flexibility to understand underlying patterns of utilization, costs, and outcomes and facilitate communication and coordination of specific quality improvement initiatives.

   The following are examples of reporting that may be analyzed by the OneCare's clinical leadership to facilitate prioritization and conduct of specific quality initiatives:

   Population Profiles:

   - Attributed population demographics (by age/sex/enrollment type/residence)
   - Attributed practice type (Patient Centered Medical Home (PCMH), non-PCMH PCP, Specialist)
   - Member counts by diagnosis groupings and other meaningful clinical categories related to health status (healthy, low-risk, multiple chronic illnesses, high-cost acute, etc.)

   Population Expenditure and Utilization Measures:

   - Actuarial analysis- costs and utilization by type of service categories, compared to benchmarks, risk adjusted and actual
   - Costs and utilization by enrollment type
   - Performance against shared savings target
   - Comparison of costs and utilization by episodes of care
   - Primary and specialty care utilization
   - Inpatient utilization
   - Prescription drug utilization
   - Emergency Department utilization (including potential avoidable and ambulatory sensitive utilization)
   - Treatment by out of area providers

   Population Quality Measures:

   - ACO Quality Measure Performance
     - Clinical data measures
     - Patient experience
     - Claims and other administrative measures
       - Engagement assessments

- Wellness visit rates
- Transitions of care

Population Opportunity Measures:

- Inpatient measures including readmission rates
- Ambulatory sensitive condition admissions and emergency department use
- Compliance with evidence based medicine guidelines
- Hospital quality data
- Provider engagement assessments

Care Coordinator Activity:

- Members identified by diagnosis grouping or other clinical category
- Members engaged in care coordination
- Number of care plans developed
- Number of referrals to other programs
- Length of time in care coordination
- Number engaged with a PCMH
- Trends in patient personal and treatment goals, barriers/challenges

Patient Level Tools/Reports:

- Disease-specific patient registries
- Care gaps/care considerations
- High risk/high cost patient lists

3. Resources, Education & Training on Quality Improvement: OneCare's past three years of collaboration with local community teams, including supporting the formation and development of Community Collaboratives, has been very instructive in guiding our learning about how best to support these teams. OneCare is committed to facilitating quality improvement efforts throughout the State by providing individual network participants, facilities, and Community Collaboratives with resources, education and training, and staffing support to promote our collective quality agenda. This "all learn, all teach" philosophy is instrumental to our ability to be nimble in testing new interventions and spreading those that prove effective across the entire ACO network. Over the past three years, OneCare has developed a variety of resources to support QI teams, these include:

   - Disease-specific change packages (e.g. congestive heart failure, chronic obstructive pulmonary disease)
   - A publicly accessible Care Coordination Toolkit
   - Templates for Community Collaborative Charters, recommendations for team structure and management
   - Real-time data reports that support identification of variations in utilization, costs, and outcomes
   - A care coordination software platform to facilitate communication among care team members and among patients and identified caregivers

   In addition, OneCare provides human resources in the form of Clinical Consultants and Regional Clinical Representatives (RCRs). Our Clinical Consultants work within their assigned communities and statewide to assist with project selection, design, and management in each health service area. The

Clinical Consultants bring data to these teams to inform and guide their focused quality initiatives as well as to monitor performance across a dashboard of quality metrics over time. The RCRs provide clinical leadership, guidance, and bi-directional communication among OneCare and the communities they serve. Thus, Clinical Consultants and RCR's serve as the "eyes and ears" within each community to promote spread of new ideas across the ACO network and to foster a dynamic learning health care system.

OneCare is supportive of the Vermont Medical Society Education and Research Foundation's physician leadership curriculum that will be offered from February 2016 through February 2018. This series of leadership training programs with faculty from the AAPL offers the type of skill training that will be especially helpful for population health management. The program has nominal participant out-of-pocket cost as it is supported by a grant from the national Physician Foundation. OneCare will encourage network providers to access these trainings.

OneCare's Clinical and Quality Improvement Department fosters a "shared learning" philosophy across our network that is built upon core adult learning principles. Thus, OneCare ensures its training and educational offerings are: timely, relevant, goal-oriented, practical, skill-based, and accessible to learners with various styles and preferences. OneCare offers synchronous and asynchronous trainings and events; "story-telling" sessions; skill-based sessions; in-person trainings such as learning sessions, written materials (e.g. clinical charters), web-based postings to a secure portal; and access to customized data displayed in a variety of ways.

8.1 Quality Management Definitions

The Contractor shall monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to its attributed members by all providers, including specialists, in all types of settings, in accordance with the provisions set forth in the contract. The Contractor shall submit quality improvement data in a time and manner as set forth by DVHA including, but not limited to, data that meets HEDIS standards for reporting and measuring outcomes.

Additionally, the Contractor must submit information requested by DVHA to complete its annual Quality Strategy Plan. This will include the results of any performance improvement projects or quality improvement projects. For purposes of this Section 8,

- A "corrective action plan" shall mean a plan to remediate an identified program deficiency in response to an action or sanction by DVHA.
- A "quality improvement project" is a planned strategy for program improvement and is incorporated into the Contractor's Quality Management and Improvement Program Work Plan.
- A "performance improvement project" shall mean a planned strategy for program improvement which adheres to CMS protocols for performance improvement projects.

8.2 Quality Management and Improvement Program

The Contractor's Medical Director shall be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program shall have objectives that are measurable and supported by consensus among the Contractor's medical and quality improvement staff. Through the Quality Management and Improvement Program, the Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at

improving the delivery of health care services that are safe, effective, timely and member centered. As a key component of its Quality Management and Improvement Program, the Contractor may develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of health care resources and improving health outcomes of ACO members.

The Contractor shall meet the requirements of 42 CFR § 438 subpart D on Quality Assessment and Performance Improvement including, but not limited to, the requirements listed below in developing its Quality Management and Improvement Program and the Quality Management and Improvement Program Work Plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to members with special needs, (ii) completion of performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects; and (iii) production of quality of care reports at least annually or as otherwise required by DVHA.

The Contractor's Quality Management and Improvement Program shall:

- Include developing and maintaining an annual Quality Management and Improvement Program Work Plan which sets goals, establishes specific objectives based upon priorities identified, identifies the strategies and activities to undertake, monitors results, and assesses progress toward the goals.

- Have in effect mechanisms to detect both underutilization and overutilization of services and the ability to report these findings to DVHA as required. The activities the Contractor takes to address underutilization and overutilization must be documented and outcomes must be reported to DVHA.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.

- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of certain target populations and other quality improvement activities requested by DVHA.

- Use Healthcare Effectiveness Data and Information Set (HEDIS) rate data, Consumer Assessment of Health Plans (CAHPS) survey data, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.

- Collect measurement indicator data related to areas of clinical priority and quality of care. DVHA reserves the right to identify areas of clinical priority and indicators of care.

- Report any national performance measures developed by CMS in the future at the request of DVHA.

- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector.

- Report the incentives offered and the results of any physician incentive program, if one has been put in place.

- Report the incentives offered and the results of any member incentive program, if one has been put in place.

- Participate in other quality improvement activities, including, but not limited to, External Quality Reviews, to be determined by DVHA.

For purposes of this section, the Parties agree that the term "participate" means DVHA may request consideration of quality improvement activities and provision of information in support of DVHA's EQRO audits in addition to the mandatory efforts required in Sections 8.2, 8.3, 8.4, 8.5, and 8.6 of this Attachment A. The Parties agree that DVHA may suggest quality improvement activities with OneCare, since both entities have responsibility for parts of the Medicaid population. The Parties agree that, while DVHA may identify clinical criteria for review, OneCare has the power to decide the priorities of its qualify management and improvement program.

8.3 Quality Management and Improvement Committee

The Contractor shall establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and Work Plan. The Contractor's Medical Director shall be an active participant in the Contractor's Quality Management and Improvement Committee. The committee shall be representative of management staff, Contractor departments, community partners, advocates, members and subcontractors, as appropriate and shall include the DVHA Medical Director or designee. Subcontractors providing direct services to members shall be represented on the committee.

The Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Contractor's Quality Management and Improvement Committee and Quality Management and Improvement Program Work Plan. All functional units in the Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with the Contractor's internal quality management and improvement committee to support the Contractor's quality management and improvement goals and objectives.

The Contractor shall have appropriate personnel attend and participate in regularly scheduled DVHA Quality Committee meetings.

8.4 Quality Management and Improvement Program Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with the Contractor's Medical Director, shall develop an annual Quality Management and Improvement Program Work Plan. The plan shall identify the Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals.

The Contractor shall submit its Quality Management and Improvement Program Work Plan to DVHA during the readiness review and annually thereafter. The Contractor shall provide progress reports to DVHA on no less than a quarterly basis. The Contractor must be prepared to periodically, as determined by DVHA, report on its quality management activities to DVHA's Quality Committee.

The Contractor shall prepare the annual Quality Management and Improvement Program Work Plan using a standardized format; the Contractor shall have discretion in proposing a template for this reporting.

8.5 HEDIS and CAHPS

In the initial year of the contract, the Contractor is not required to contract with a certified HEDIS Auditor or a certified CAHPS survey to tabulate the results of outcome measures pertaining to the DVHA members attributed to the ACO. Instead, the Contractor will work in close collaboration with DVHA and its contracted HEDIS Auditor and CAHPS survey firm in the sampling of DVHA members both attributed and not attributed to the ACO.

For the tabulation of HEDIS measures, the Contractor will be responsible at the request of DVHA to conduct chart reviews in the field on hybrid HEDIS measures among ACO-affiliated providers representing its proportion of all DVHA members in the denominator of specified HEDIS measures. DVHA staff will conduct the remaining chart reviews to represent the non-attributed members that it manages.

In contract years after the first year of the contract, DVHA reserves the right to request that the ACO contract directly with a certified HEDIS auditor or conduct a CAHPS survey to collect information annually on DVHA members attributed to the ACO.

8.6 External Quality Review

Pursuant to federal regulation, DVHA is subject to external quality reviews. The Contractor shall provide all information required for this review in the timeframe and format requested by the External Quality Review Organization. The Contractor shall cooperate with and participate in all external quality review activities, as requested. The Contractor's Quality Management and Improvement Program should incorporate and address findings from these external quality reviews.

8.7 Incentive Programs

8.7.1 Quality Incentive Pool Program

Contractor shall participate in a Quality Incentive Pool Program that focuses on rewarding the Contractor's efforts to improve quality and outcomes for its attributed members. That Quality Incentive Pool Program is described in Attachment B.

8.7.2 Provider Incentive Programs

In addition to the pay for outcomes program in Section 8.7.1, the Contractor may establish other incentives for its providers. The Contractor will determine its own methodology for incentivizing providers. The Contractor must obtain DVHA approval prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs. However, the Contractor shall be cognizant and comply with federal regulations regarding physician incentive plans as stated in 42 CFR § 538.8(h).

The Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member.

8.7.3 Member Incentive Programs

The Contractor may establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non-financial. The Contractor will determine its own methodology for providing incentives to members. The

Contractor must obtain DVHA approval prior to implementing its member incentive program and before making any changes thereto.

DVHA encourages creativity in designing pay for performance programs. However, the Contractor may not offer gifts or incentives greater than $10.00 for each incentive and not to exceed $50.00 total per year per individual. In any member incentive program, the incentives shall be tied to appropriate utilization of health services and/or health-promoting behavior.

9.0 Performance Reporting

9.1 ACO Reporting Manual

The State places great emphasis on the delivery of quality health care to Medicaid members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered. DVHA uses various performance targets, industry standards, national benchmarks and program-specific standards to review and monitor the Contractor's performance and clinical outcomes. The Contractor shall submit performance data specific to the Medicaid ACO program unless otherwise specified by DVHA. DVHA reserves the right to publish the evaluation of the ACO's performance and/or recognize the Contractor when it exceeds performance indicators.

The Contractor shall comply with all reporting requirements set forth in this Section as well as the ACO Reporting Manual. As referenced in Section 2.16 of this Attachment A, the ACO Reporting Manual will contain a catalog of the reports that will be required to be submitted by the Contractor to DVHA and the periodicity schedule of each report submission. For the majority of reports, DVHA will provide both a report template (most of which will be developed in Microsoft Excel) and instructions for how to complete each report. The Contractor will have discretion to propose the format for reports for which DVHA does not supply templates. It is anticipated that some reports will be submitted monthly, some quarterly, some semi-annually, and others annually. DVHA may change the frequency of reports and may require additional reports. DVHA shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. DVHA may request ad hoc reports at any time.

The Contractor shall submit the requested data completely and accurately within the requested or required timeframes and in the formats identified by DVHA. Throughout the initial implementation, some specific reporting, identified by DVHA, may occur more frequently until Contractor demonstrates that its performance is consistent and meets the State's requirements and standards. The State reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors.

The Contractor shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to DVHA is materially accurate and materially complete. The Contractor shall submit its performance data and reports under the signatures of any key leadership members of OneCare, as set forth in Section 2.5.1 certifying the Contractor's data is materially accurate and materially complete. The ACO Reporting Manual will include the reporting requirements that are highlighted below.

DVHA reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions and will assess liquidated damages, as specified, in Attachment B, for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

Reporting required in the ACO Reporting Manual includes:

9.1.1 Financial Reports

Financial Reports assist DVHA in monitoring the Contractor's financial trends to assess its stability and continued ability to offer health care services to its members. If the Contractor does not meet the financial reporting requirements, DVHA shall notify the Contractor of the non-compliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor shall provide a written response to the notification. Examples of Financial Reports to be submitted by the Contractor include, but are not limited to:

- Financial Stability Indicators;
- Reimbursement for FQHC and RHC Services; and
- Physician Incentive Plan Disclosure.

9.1.2 Member Service Reports

Member Service Reports identify the methods the Contractor uses to communicate to members about preventive health care and program services and monitor member satisfaction. Examples of Member Service Reports to be submitted by the Contractor include, but are not limited to:

- Member Helpline/Provider Network Performance Report;
- Member Complaint Report;
- Member Appeals Report;
- Member Website Utilization Report; and
- Marketing and Outreach Report.

DVHA shall have the right to require more frequent Member Service reporting, especially at the beginning of the Contract and during implementation of program changes as necessary to ensure satisfactory levels of member service throughout the Contract term.

For purposes of this section, the Parties agree that the Member Helpline Performance Report may be combined with data from the Provider Network Helpline Report.

For purposes of this section, the Parties agree that OneCare shall produce a monthly member compliant report and a monthly member appeals report.

9.1.3 Network Development Reports

Network Development Reports assist DVHA in monitoring the Contractor's network composition by specialty and geographic location in order to assess member access and network capacity. The Contractor shall fulfill this section's report requirement by fulfilling the requirements of Section 5.0 subparagraph c of this Attachment A.

9.1.4 [intentionally omitted]

9.1.5 Quality Management Reports

Quality Management Reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports

assist DVHA in monitoring the Contractor's quality management and improvement activities. Examples of Quality Management Reports to be submitted by the Contractor include, but are not limited to:

- Quality Management and Improvement Program Work Plan;
- Quality Management Committee Meeting Minutes;
- Quality Improvement Program Statistical Analysis;
- Return on Investment of Provider Incentive Programs; and
- Return on Investment of Member Incentive Programs.

9.1.6 Utilization Reports

Utilization Reports assist DVHA in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members. Examples of Utilization Reports to be submitted by the Contractor include, but are not limited to:

- HEDIS-like utilization metrics using claims data only.

Prior authorization reports shall not be required.

9.1.7 Care Management Reports

Care Management Reports assist DVHA in monitoring the number and stratification of DVHA's ACO members in care management levels by condition of interest. Examples of Care Management Reports to be submitted by the Contractor include, but are not limited to:

- Initial Health Screenings Report;
- Comprehensive Health Screenings Report; and
- Reports by Level of Care Management: low, medium, high and very high

9.1.8 [intentionally omitted]

9.1.9 CMS Reporting

The Contractor shall provide DVHA with data requested by the Centers for Medicare and Medicaid Services (CMS) to meet the reporting obligations described in the CMS Special Terms and Conditions (STCs) for the State's Global Commitment waiver or State Innovation Model (SIM) grant reporting. CMS often requests additional data and reports in advance of DVHA's monthly conference calls with CMS. In preparation for these calls, DVHA will ask the Contractor for data requested by CMS. The Contractor shall submit this data in the timeframe specified by DVHA.

9.1.10 Other Reporting

DVHA shall have the right to require additional reports to address program-related issues that are not anticipated at the time of the RFP release but are determined by DVHA to be necessary for program monitoring.

10.0 Information Systems

10.1 Definitions

The following terms are used to describe the Contractor's and DVHA's activities in this engagement as it relates to information systems.

ACO-Affiliated Provider, or ACO-Contracted Provider – A Provider enrolled with Vermont Medicaid, and with whom an ACO has a contractual relationship, regarding the services within the scope of the ACO contract with DVHA.

Fee for Service (FFS) Claim – A claim that is paid directly to Providers, due to one or more of the following situations: a) the service provided is not within the scope of ACO covered services; b) the member is not attributed to the ACO; c) the Provider is not affiliated with the ACO; and/or d) the provider is an affiliated non-hospital provider.

Zero-Paid Claim – A claim submitted to DVHA by an ACO-affiliated provider, which is paid zero dollars with an Explanation of Benefits (EOB) code indicating that the member and services are covered by the ACO. ACO-Affiliated Providers are reimbursed for ACO-covered members and ACO-covered services by the ACO.

WHPP Claim Amount – Would Have Paid Provider (WHPP) amount is the calculated amount for an adjudicated zero-paid claim that the DVHA would have paid if it were a FFS claim. The DVHA Medicaid Management Information System (MMIS) utilizes the same pricing rules to calculate both the paid amount on FFS claim payments and WHPP claim amounts. The WHPP claim amounts for zero-paid claims are reported to the ACO as part of the Medicaid Decision File for informational purposes. The WHPP amount is not included in Remittance files to providers.

Medicaid Provider Remittance Advice Files – Providers will continue to receive Remittance Advices (in paper format or as 835 X12 files), containing final dispositions for all claims submitted to Vermont Medicaid (both FFS paid claims and zero-paid claims). The RAs will include an Explanation of Benefits (EOB) code to indicate those claims that have been zero paid and that have been reported to the ACO.

HPE –Enterprises Services, LLC, the fiscal agent contracted by DVHA to perform the information system functions that are the responsibility of DVHA related to this contract.

Third Party Liability (TPL) – TPL refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan.

Coordination of Benefits (COB) – COB refers to the activities involved in determining Medicaid benefits when a DVHA member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency. Examples of third parties which may be liable to pay for services: Group health plans, Self-insured plans, Managed care organizations, Pharmacy benefit managers, Medicare, Court-ordered health coverage, Settlements from a liability insurer, Workers' compensation, Long-term care insurance, Other state or Federal coverage programs (unless specifically excluded by law).

10.2 Summary of Contractor Information System Responsibilities

The Contractor shall have an Information System (IS) sufficient to support the Medicaid ACO program requirements, and the Contractor shall be prepared to submit all required data and reports accurately and completely in the format specified by DVHA. The Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Scope of Work.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with the Contractor in establishing the new technical requirements. The Contractor shall be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. Contractor-initiated changes to the requirements shall require DVHA approval. The Contractor is required to pay for new technical requirements for its own systems.

The Contractor shall develop processes for developing, testing, and promoting system changes and maintenance. The Contractor shall notify DVHA prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements that may impact mission critical business processes, such as file exchanges with the State's fiscal agent, service authorization management, provider payment data management, case management files, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors.

The Contractor shall have written policies and procedures sufficient to manage the Medicaid ACO program. These policies and procedures will ensure accurate and valid provider payment detail data and will reflect that services delivered to members and payments made to providers are made in compliance with State and Federal regulations and in accordance with this Contract. These policies shall address the submission of provider payment data from any sub-capitated providers or subcontractors. DVHA shall monitor the Contractor's performance utilizing a random sample audit of all program documentation and payments. DVHA will review the Contractor's compliance with its internal policies and procedures to ensure the accuracy and timeliness of the payments to providers and services provided to members. The Contractor is required to comply with the requirements of the review and audit and to provide all requested documentation. DVHA shall require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with payment accuracy reporting standards.

The Contractor will provide DVHA with a project plan for all system changes or system upgrades associated with this contract. The project plan will include but is not limited to: project timeline, costs, milestones, deliverables, testing processes and protocols, criteria for a go-no go decision, contingency plan and mitigation strategies. The Contractor will provide the project plan to DVHA allowing for a thirty (30) day review. The Contractor will proceed with the plan changes upon written acceptance and approval of the plan.

The Contractor shall have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), which address security and privacy of individually identifiable health information.

The Contractor shall attend in person any meetings hosted by DVHA or its fiscal agent in relation to the development of and the ongoing remediation of any issues that arise from the data exchange process. Notwithstanding any scheduled meetings where these issues may be

addressed, the Contractor shall report any problems with data submissions to the designated DVHA Contract Compliance Manager.

10.3 Security and Privacy Practices

The Contractor's IS shall meet the requirements as specified by DVHA. The Contractor's electronic mail encryption software for HIPAA security purposes must be compatible with DVHA's and with DVHA's fiscal agent email software.

The Contractor's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

The Contractor shall make all data available to DVHA and, upon request, to CMS. In accordance with 42 CFR § 438, subpart H, which relates to certifications and program integrity, the Contractor shall submit all data, under the signatures of either its Chief Financial Officer or Chief Executive Officer certifying the accuracy, truthfulness and completeness of the Contractor's data. Software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d). Any deviation from these architecture requirements shall be approved in writing by DVHA in advance. The Contractor shall comply with all DVHA Application Security Policies. Any deviation from DVHA policies shall be approved in writing.

10.3.1 Disaster Recovery Plan

Information system contingency planning shall be developed in accordance with the requirements of this Section and with 45 CFR § 164.308, which relates to administrative safeguards. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures shall also be addressed within the Contractor's contingency plan documents. The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software, and shall back up and store its data in an off-site location.

For purposes of this Attachment A, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. DVHA and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include, but is not limited to, natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

The Contractor shall notify DVHA, at minimum, within four (4) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as processing affecting the Contractor's capability to interface with the State or the State's contractors. Depending on the anticipated length of disruption, DVHA, in its discretion, may require the Contractor to provide DVHA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster, the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. In the event of other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

DVHA will review the Contractor's Disaster Recovery Plan during the Readiness Review process and may review it at any time after contract initiation upon request.

10.4 Data File Exchanges

This Contractor will be responsible for the receipt and delivery of file exchanges with the State's fiscal agent. The Contractor must accept and submit data files in electronic format, currently via secure file transfer protocol ("SFTP") or as directed by DVHA. DVHA shall have the right to amend the data transfer process during the Contract term.

The Contractor's information systems must utilize the State's unique identification number (UID) to properly identify each member.

The list of data file exchanges is summarized below; however, this list may change in number and/or periodicity at any time during the course of the contract based on the needs of the State.

File Name	Inbound to DVHA (or HPE)/ Outbound from DVHA (or HPE)	Periodicity
ACO Affiliated Provider File	Inbound	Weekly
Medicaid Member Attribution File	Outbound	Monthly
ACO Member Demographics File	Outbound	Monthly
Medicaid Decision File	Outbound	Weekly
Medicaid FFS Payments File	Outbound	Weekly
Medicaid ACO Confidential Claims File	Outbound	Weekly
Medicaid FFS Confidential Claims File	Outbound	Weekly
ACO Non-Claims Payments File	Inbound	Monthly
Medicaid ACO Remittance File	Outbound	Monthly
ACO PMPM File	Outbound	Monthly
ACO Case Management File	Inbound	Monthly

Medicaid-ACO File Exchange Definitions, Requirements and Uses

The first word in the file name indicates who is responsible for generating the file, while the rest of the name is descriptive about the file content. The organizations involved in file exchange are noted in parentheses.

10.4.1 ACO Affiliated Provider File

(ACO to HPE) This file contains the current list of Vermont Medicaid enrolled providers who are affiliated with the ACO, including a method of identifying changes. The Contractor shall submit provider roster updates to the State's fiscal agent in an agreed upon format and process. The Contractor shall keep provider enrollment and disenrollment information up-to-date.

10.4.2 Medicaid Member Attribution File

(DVHA to HPE for initial attribution, HPE to ACO ongoing) This file contains information including the list of members currently attributed to the ACO. The HPE MMIS system will store and maintain the member attribution status, including the history of changes to member status that may impact per member per month (PMPM) payments (such as death, Medicaid eligibility, or third party primary coverage). The effective date of any retrospective change will also be reported.

10.4.3 Medicaid ACO Remittance File

(HPE to ACO) This file contains the details of Per Member Per Month (PMPM) payments made by DVHA to the ACO.

The Contractor shall be responsible for reconciling capitation payments against the Medicaid Member Attribution File and identifying any errors or omissions to the State's fiscal agent within ten (10) business days of receipt of the Medicaid ACO Remittance File.

10.4.4 Medicaid Decision File

(HPE to ACO) This file contains information related to claims submitted by ACO-affiliated providers for ACO-covered services for all attributed members to the ACO. The Medicaid Decision File contains DVHA's disposition of the claim status which may be paid (zero-paid claims) or denied (with denial reason).

DVHA's fiscal agent will continue to receive all claims from Vermont Medicaid providers. All claims will continue to be processed through DVHA's edits and audits.

Upon initiation of this contract, DVHA's fiscal agent will identify all claims that need to be passed to the Contractor for payment that meets the criteria for:

- An attributed member to the ACO;
- A contracted provider with the ACO; and
- A service that is included in the capitation payment to the ACO.

When claims meet all of these criteria, DVHA's fiscal agent will assign a paid or denied status to the claim which represents the disposition of the claim under fee-for-service pricing logic. When the claim status is paid, the fiscal agent will assign a payment of $0

to the claim. Claims identified as the responsibility of the ACO will be provided to the ACO Contractor on an agreed upon schedule. The ACO will then be responsible for any additional review of the claims and payment to ACO contracted providers for services rendered.

The Contractor shall review data provided by DVHA's fiscal agent and either deny or make payments to providers within fourteen (14) calendar days of receipt.

10.4.5 [intentionally omitted].

10.4.6 ACO Non-Claims Response File

(ACO to HPE) This file contains payments the ACO has made to their affiliated providers which were not paid at a claim level.

10.4.7 Medicaid FFS Payments File

(HPE to ACO) This file contains paid claims data for all attributed members to the ACO paid by DVHA on a fee-for-service basis: a) for Medicaid services not included in the ACO capitated payment but provided to ACO members; or b) for ACO capitated services provided to ACO members by non-ACO providers.

10.4.8 [intentionally omitted]

10.4.9 ACO Case Management File

(ACO to HPE) This file contains data elements related to ACO attributed members who have been case managed by the ACO. Elements of the file that will be transmitted are anticipated to include the member UID, diagnoses, start and end date receiving case management, the reason for case management, the level of case management, elements in the case management/treatment plan, the member's compliance with the case management/treatment plan, and evaluation of whether the case management was successful. The Parties will mutually decide on contents of this report.

10.4.10 ACO Member Demographics File

(DVHA to ACO) This file contains summary demographic information on all attributed Medicaid members. The file will be generated on a monthly basis.

10.4.11 Medicaid ACO Confidential Claims File

(DVHA to ACO) This file contains payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the ACO will not receive claim-level detail) provided to the ACO attributed members which HPE considered ACO covered services. This file will be generated weekly.

10.4.12 Medicaid FFS Confidential Claims File

(DVHA to ACO) This file contains payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the ACO will not receive claim-level detail) provided to ACO attributed members which HPE paid fee for service. This file will be generated weekly.

10.4.13 Medicaid ACO PMPM File

(HPE to ACO) In addition to the remittance advice, a summary file will be generated containing PMPM payment information for each attributed member. The file will contain all of the attributed members for whom a PMPM payment was made along with the PMPM amount, and all of the attributed members for whom a payment was not made including the reason the payment was not made.

10.5 Third Party Liability (TPL) Issues

Upon initiation of the contract, Vermont Medicaid members who have third party coverage of any kind will not be attributed to the Contractor. If the Contractor becomes aware that one of its DVHA members obtains third party coverage or is enrolled with another insurer, the Contractor is responsible for reporting this information to DVHA's fiscal agent within five (5) calendar days.

When the Contractor has identified members who have newly discovered health insurance, members who have changed coverage, or members who have casualty insurance coverage, the Contractor will provide the State and its fiscal agent the following information:

- Member name/UID number/Social Security number
- Carrier name/address/phone number/contact person
- Policyholder name/address/Social Security number/relationship to member
- Policy number/Group Number/effective date/coverage type

When a DVHA member who is attributed to the Contractor obtains third party insurance coverage, the capitation payments prospectively will cease and any capitation payments made previously that were determined to be inappropriate after the fact will be recouped by DVHA in a year-end reconciliation. Additional specifications related to the recoupment of payments from third party insurance ("chasing payments") and how this activity interplays with the year-end reconciliation will be detailed in the ACO Operations Manual and will be made available to the Contractor prior to the readiness review process.

10.6 Year End Reconciliation Process

DVHA will complete a year end reconciliation process on or about 180 days after the end of each 12-month contract performance period to reconcile any payments owed from or to the Contractor over the course of the previous 12-month period. The files described in Section 10.4 will serve as the primary basis for this reconciliation. However, on an as needed basis, DVHA may request from the Contractor additional files to exchange with DVHA's fiscal agent to support this year end reconciliation. The Contractor agrees to provide these files as requested.

There may be situations where, due to new knowledge of retrospective TPL, items that would normally be accounted for in the year end reconciliation will not be accounted for because they become known more than 180 days after the end of the 12-month contract period. In this situation, the retrospective TPL adjustment items will be accounted for in the next year's reconciliation process.

10.7 Health Information Technology and Data Sharing

The use of Health Information Technology (HIT) has the potential to improve the quality and efficiency of health care delivery. The Contractor shall cooperate and participate in the development and implementation of current and future DVHA- or State-sponsored HIT initiatives. Contractors must complete and participate in data sharing agreements with any health information technology entity required by DVHA.

11.0 Program Integrity

The contractor shall comply with three important provisions of Program Integrity (PI). As more fully set out below, the contractor shall comply with (1) the provider contracting requirements found in Section 5.3 of Attachment A of this contract, (2) the requirements for a Program Integrity Plan (as set forth and agreed to by DVHA below) and (3) the requirement for ongoing monitoring of the Contractor's provider network (as set forth below). DVHA agrees that the Program Integrity Requirements are met as set forth in Section 11.0(A).

11.0(A) OneCare Vermont will establish a Compliance Committee comprised of OneCare Vermont staff and chaired by the Compliance Officer who are responsible to senior management. 42 C.F.R. § 438.608(b)(2). The Compliance Committee will develop a detailed plan to efficiently identify, investigate and refer fraud, waste and abuse to DVHA's Program Integrity unit primarily by analyzing the data available to OneCare Vermont from DVHA. 42 C.F.R. § 438.608(b)(6). The Compliance Committee will also monitor external data, such as the exclusion list to identify potential fraud, waste and abuse. *Id.* The Compliance Officer and OneCare employees will act cooperatively with and maintain communication with DVHA's Program Integrity Unit, to make prompt reports and participate in the development of corrective action plans. 42 C.F.R. § 433.608(b)(7).

OneCare will establish a code of conduct for all employees and Board members that requires compliance with all applicable state and federal laws and regulations. 42 C.F.R. §438.608(b)(1). The code of conduct, or other equivalent policy document, will include information about the standards of conduct, policies and procedures as well as a prohibition against retaliation for reporting compliance concerns. The code of conduct will set forth lines of communication between OneCare representatives and the Compliance Officer and encourages the reporting of concerns. 42 C.F.R. § 433.608(b)(4) (5) the Compliance Officer or his/her designee will conduct employee training and education regarding fraud, waste and abuse, and will personally secure his/her own training. *Id.*

OneCare Operations, who are responsible for staffing the toll-free Member services and provider relations phone line, will be provided training for the detection of potential fraud, waste and abuse and parameters for the reporting of such information or suspicions (regarding providers or members) to the appropriate personnel.

Provider contracts will contain requirements to maintain active Medicaid participation, to report any events that may impact that participation and to immediately report any termination from Medicaid. Providers must also supply their Medicaid billing numbers. Those contacts will also require, both the participants and OneCare Vermont, to comply with all applicable federal, state and local laws and regulations.

OneCare will work with its Compliance Officer and Compliance Committee to ensure that: compliance policies are up to date; annual training and education occurs; and provisions are in place to detect fraud, waste and abuse and for the development of corrective action initiatives. The Board of Managers will receive reports on and exercise oversight over the compliance activities. All of the aforementioned activities shall comply with the applicable requirements outlined in 42 C.F.R. § 438.608(b)(1) – (7) and in Attachment A, Section 11, pgs. 86-88 of the RFP.

On a quarterly and annual basis, OneCare shall make available upon request, detailed reports to DVHA outlining results on key metrics of cost, utilization and quality to identify variances that may inform PI activities. The following illustrative table indicates the type of reports that could be made available, the frequency of the report, the responsible party, the responsible committee and the frequency by which the committee reviews the reports, and shares the results of these reviews with the Compliance Committee (42 C.F.R. § 438.608(b)(4).

Table: Sample of Detailed Report

Report Type	Frequency	Reviewer(s)	Committee(s)	Frequency
Days per 1000	Monthly	CMO, RCRs, and Clinical and Quality Director	CAB, Population Health and BOM	Quarterly
Average LOS	Monthly	CMO, RCRs, and Clinical and Quality Director	CAB, Population Health and BOM	Quarterly
ER Utilization per 1000	Monthly	CMO, RCRs, and Clinical and Quality Director	CAB, Population Health and BOM	Quarterly
Readmissions per 1000 (based on Quality measures)	Monthly	CMO, RCRs, and Clinical and Quality Director	CAB, Population Health and BOM	Quarterly
UM Flash Reports	Monthly	CMO and Clinical and Quality Director	BOM	Monthly
DVHA HEDIS Measures	Quarterly	CMO, RCRs, and Clinical and Quality Director	QIC, Population Health, CAG and BOM	Quarterly
Next Gen Quality Measures	Quarterly	CMO, RCRs, and Clinical and Quality Director	QIC, Population Health, CAG and BOM	Quarterly
Commercial Quality Measures	Quarterly	CMO, RCRs, and Clinical and Quality Director	CAB, Population Health, CAG and BOM	Quarterly
Care Coordination Outcomes	Quarterly	CMO, RCRs, and Clinical and Quality Director	Population Health, CAG and BOM	Quarterly
Beneficiary/Member Experience	Annually	CMO, RCRs, and Clinical and Quality Director	CAB, QIC Population Health and BOM	Annually
Medical Expense Targets	Monthly	Finance Officer	Finance Committee and BOM	Monthly
Member Services (Complaints)	Quarterly	CMO, RCRs, and Clinical and Quality Director	QIC, CAG Population Health and BOM	Quarterly
Network (Access and Compliance)	Quarterly	ACO Programs Director	BOM	Quarterly

Annually, OneCare will also conduct a comprehensive evaluation of the Quality, Experience, Total Cost of Care and Utilization outcomes to identify accomplishments, opportunities for improvement and to develop interventions to address identified opportunities. This evaluation will include, but not be limited to procedures to evaluate the service variances (under/over utilization), appropriateness, efficacy or efficiency of health services provided by OneCare participants as well as member satisfaction. The OneCare QIC and Population Health Strategy Committee will review the annual evaluation. The BOM will ultimately approve the evaluation and the results will be made available to DVHA.

11.1 Provider Contracting

Under Section 5.3 of this Attachment A, the contractor must ensure that each provider in its network has been enrolled in the Vermont Medicaid Program. The Contractor warrants, and is responsible for ensuring, that as a condition of participation with OneCare, its network providers will have entered into and keep current a Medicaid provider agreement.

Because Vermont Medicaid will perform Medicaid required screening and enrollment for ACO network providers, the Contractor need not incur this cost.

11.2 Program Integrity Plan

Pursuant to 42 CFR § 438.608, which sets program integrity requirements, the Contractor must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan shall serve as the Contractor's compliance plan. The Program Integrity Plan shall incorporate the collaboration with the DVHA PI Unit's fraud, waste and abuse efforts and shall be submitted annually and more frequently if required by the DVHA PI Unit. The Program Integrity Plan and/or updates to the Program Integrity Plan shall be submitted through the reporting process to DVHA, who shall forward to the DVHA PI Unit, ten (10) business days prior to scheduled meetings discussing the Plan. The Plan shall include provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of vendors, subcontractors and the Contractor itself. Although provider fraud, waste and abuse will be investigated by the DVHA PI Unit, the contractor should have mechanisms to report identified or alleged instances. The Program Integrity Plan shall also include:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.
- The designation of a Compliance Officer and a Compliance Committee.
- The type and frequency of training and education for the Compliance Officer and the organization's employees who will be provided to detect fraud. Training must be annual at a minimum and address the False Claims Act, Federal and Vermont laws and requirements governing Medicaid reimbursement and the utilization of services. In particular, this shall include changes in rules and other federal and state laws governing Medicaid provider participation and payment as directed by CMS and DVHA. Education regarding the False Claims Act of staff of the contractor must be provided to DVHA in its Program Integrity Plan.

- A risk assessment of the Contractor's compliance plan and contractual requirements with providers and subcontractors, as well as other programmatic policies shall be submitted on an 'as needed' basis and updated after program integrity-related actions, including financial-related actions (such as overpayment, repayment and fines), are taken. The Contractor shall inform the DVHA PI Unit of such actions in its audit plan. The assessment shall also include a listing of the Contractor's top three (3) vulnerable areas and shall outline action plans mitigating such risks.

- An organizational chart and communication plan highlighting lines of communication between the Compliance Officer and the organization's employees.

- Provision for internal monitoring and auditing.

- A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:

- A list of provisions in the subcontractor and provider contracts that ensure the integrity of provider credentials.

- A list of provisions for the confidential reporting of PI Plan violations to the Compliance Officer or designated person.

- A list of provisions for the adherence to ACO related regulations and applicable waivers granted under the Affordable Care Act, Stark Law, Anti-kickback statute, civil money penalty law (CMP), Gainsharing CMP, and incentives.

- Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.

- Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.

- Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under state or federal law to the DVHA PI Unit and pursuant to section 11.1.3 below.

- Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

- Compliance and Program integrity-related goals, objectives and planned activities for the upcoming year.

11.3 Ongoing Monitoring of the Contractor's Provider Network

The Contractor shall have adequate staffing and resources to monitor provider and sub-contractor contracts to ensure compliance.

The Contractor will work collaboratively with the DVHA PI Unit and will develop and implement any necessary corrective action plans required of the Contractor. The Contractor shall further require their contracted providers or subcontractors to comply with any requested corrective action plans as a result of fraud and abuse activities identified by either the Contractor or the DVHA PI Unit.

The Contractor shall cooperate with all appropriate state and federal agencies, including the Medicaid Fraud and Residential Abuse Unit (MFRAU) and the DVHA PI Unit, in investigating fraud and abuse.

The Contractor shall promptly refer all incidents of suspected fraud, waste and abuse to the DVHA PI Unit.

On a quarterly basis, and as otherwise directed by the DVHA PI Unit, the Contractor shall submit a detailed Report to DVHA which outlines the Contractor's compliance and program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives.

The Contractor agrees that the DVHA Program Integrity Unit is responsible for overseeing the integrity of all Medicaid Payment, including the underutilization of services or the over reporting of services such as split billing, unbundling of services or other billing methods that would cause ACO capitation to increase artificially.

The Contractor agrees that the DVHA PI Unit may conduct oversight reviews of the Contractor's Compliance or Program Integrity related activities to determine the effectiveness of Contractor's operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for such activities, and reviewing any performance metrics. The DVHA PI Unit may issue a corrective action or performance improvement plan and outline timelines for improvement measures.

THE CONTACTS FOR THIS AWARD ARE AS FOLLOWS:

	State Fiscal Manager	State Program Manager	Contractor
Name	Michael Costa	Alicia Cooper	Victoria Loner
Telephone	802-498-8686	802-585-4860	802-847-6255
Email	Michael.Costa@Vermont.gov	Alicia.Cooper@Vermont.gov	Victoria.Loner@OneCareVT.org

NOTICES TO THE PARTIES UNDER THIS AGREEMENT

To the extent notices are made under this agreement, the parties agree that such notices shall only be effective if sent to the following persons as representative of the parties:

	STATE REPRESENTATIVE	CONTRACTOR/GRANTEE
Name	DVHA, Commissioner's Office	Victoria Loner
Address	NOB 1 South, 280 State Drive Waterbury, VT 05671-1010	OneCare Vermont 256 Mountain View Drive, Ste. 301 Colchester, VT 05446
Email	ahs.dvhalegal@vermont.gov	Victoria.Loner@OneCareVT.org

The Parties agree that notices may be sent by electronic mail except for the following notices which must be sent by United States Postal Service certified mail: termination of contract, contract actions, damage claims, breach notifications, alteration of this paragraph.

DVHA MONITORING OF CONTRACT

The Parties agree that the DVHA official State Program Manager is solely responsible for the review of invoices presented by the Contractor.

SUBCONTRACTOR REQUIREMENTS: Per Attachment C, Section 15, if the Contractor chooses to subcontract work under this agreement, the Contractor must first fill out and submit the Subcontractor Compliance Form (Appendix I – Required Forms) in order to seek approval from the State prior to signing an agreement with a third party. Upon receipt of the Subcontractor Compliance Form, the State shall review and respond within five (5) business days. A fillable PDF version of this Subcontractor Compliance Form is available upon request from the DVHA Business Office. Under no circumstance shall the Contractor enter into a sub-agreement without prior authorization from the State. The Contractor shall submit the Subcontractor Compliance Form to:

Contract Manager
Susan Whitney
Susan.Whitney@Vermont.gov

Should the status of any third party or Sub-recipient change, the Contractor is responsible for notifying the State within fourteen (14) days of said change.

ATTACHMENT B
PAYMENT PROVISIONS

SECTIONS

The parties agree that the following definitions apply to Attachment A and B.

A. Definitions:

1. AIPBP: All Inclusive Population Based Payments. The financial obligation from DVHA to ACO for covered members. The AIPBP includes all of the following components:

a. Primary Care Case Management ("PCCM") Fee of $2.50 per attributed member per month;
b. Administrative funding of $6.50 per attributed member per month for the ABD MEG, Consolidated Adult MEG, and Consolidated Child MEG;
c. A monthly payment in an amount designated by OneCare as reimbursement for services provided to attributed members by participating hospitals designated by OneCare. This payment shall be referred to as a fixed prospective payment (FPP); and
d. Fee for service payments made for services to attributed members to OneCare.

The AIPBP is comprised by multiplying the rate in Column A times the number of members in each MEG that are attributed to OneCare. AIPBP is paid prospectively on a monthly basis from DVHA. The AIPBP varies by MEG (Medicaid Eligibility Group).

1. Medicaid Eligibility Group ("MEG") – attributed members will be in one of three groups: (1) Adult; (2) Child or (3) Aged Blind Disabled (ABD) Adult or Child.

2. NET AIPBP (Column G Page 86): This payment is derived by using the AIPBP (column A), multiplying this rate times the members in each MEG and subtracting the expected fee for service allocation payments (Column C below) for each member. The NET AIPBP is paid prospectively on a monthly basis, and is inclusive of the PCCM fee payments (Column F), the administrative rate payments (Column E) and the FPP payment (Column D).

3. Actual Total Cost of Care (ATCOC): FPP (column D) times each member month plus fee for service payments made by DVHA for each attributed member for covered services under Attachment A for the entire year.

4. Risk Corridor: A percentage of the total cost of care that individual parties to the contract agree to assume payment risk.

5. Risk Corridor Benchmark or expected total cost of care (ETCOC) (Column B Page 86): The risk corridor benchmark is the sum of money to which the parties agree that risk corridor percentages apply. The benchmark is computed by multiplying the Total Cost of Care rates in Column B below (or expected total cost of care) times the number of member months for each MEG.

6. ABD: A subgroup of attributed Medicaid eligible that are Aged, Blind or Disabled under 42 U.S.C. §1396a (a) (10) (A)(i)(I) and (II) & (10) (A) (ii).

7. Consolidated Children: A subgroup of attributed Medicaid eligible that are children (under 21) eligible under 42 U.S.C. §1396a (a)(10)(A)(i)(III)-(IX) & (10)(A)(ii).

8. Consolidated Adults: A subgroup of attributed Medicaid eligible that are adults eligible under 42 U.S.C. § 1396a (a)(10) (A)(i)(III)-(IX) & (10)(A)(ii).

9. Reconciliation: The process that occurs at the end of the contract period where there is a comparison of the Risk Corridor Benchmark and the Total Cost of Care. This process will determine whether Risk Corridors have been reached.

B. METHODOLOGY FOR EXPECTED TOTAL COST OF CARE (ETCOC)

The parties agree that an actuarial rate set in this contract is based upon the following methodology:

Calculation of ETCOC

i. Determine attributed beneficiaries and allocate each attributed beneficiary to a MEG.

ii. Identify all base year 2015 claims for attributed beneficiaries that meet program parameters.

iii. Calculate the baseline expenditure on a per member per month (PMPM) basis for each of the three MEGs.

iv. For each MEG, trend the 2015 claims forward to 2017 by applying:

1. A trend factor, agreed to by the Parties, that combines the impact of both utilization and rate changes for the period of 2013-2015 for continuously enrolled beneficiaries will be applied to the 2015 claims PMPM to calculate the pre-adjusted ETCOC PMPM for each MEG

2. The trend factor for each MEG will be adjusted for mutually agreed upon, material external changes in underlying reimbursements or policies that are not expected to continue into the performance year. By way of example, OneCare would be held harmless from increases in pediatric care reimbursement implemented for a limited time under the Affordable Care Act.

v. Apply ACO Efficiency Factor

1. ACO efficiency – A 0.2% reduction will be applied to the 2017 pre-adjusted ETCOC PMPM for each MEG. The result will be referred to as the Expected TCOC (ETCOC). 0.5% quality withhold to be used as set forth in Section J of this Attachment

2. The 2017 ETCOC PMPM amounts for each MEG are in a table contained in Section D.2 of the agreement.

C. General Payment Provisions

The maximum dollar amount payable under this agreement is not intended as any form of a guaranteed amount. The Contractor will be paid for products or services actually performed as specified in Attachment A up to the maximum allowable amount specified in this Agreement.

Work performed between January 1, 2017 (retroactive date) and the signing or execution of this agreement that is in conformity with Attachment A may be billed under this agreement.

This is generally a risk sharing arrangement wherein the DVHA holds OneCare accountable to an AIBPB to cover the cost of delivering covered and specified medical care to an attributed group of Medicaid beneficiaries that is then measured against the actual expenditures by DVHA to providers for delivering that care. OneCare will deliver the medical care through its network of participants and beneficiaries may receive care from DVHA participating providers as well as out of network providers. Within the risk corridors as defined below, and as more specifically set forth below, if the actual cost of care (ATCOC) is greater than the expected total cost of care (ETCOC), OneCare shall pay DVHA and if the actual cost of care is less than the expected cost of care, DVHA shall pay OneCare.

The Parties acknowledge that this financial agreement is based on calculations that rely on underlying data from DVHA, which has been assumed to be valid and accurate. To the extent that it is discovered, that there is a material error(s) in the underlying data, by way of example the categorization of Beneficiaries in MEGs, they will work together to remedy the material error(s) and re-negotiate these payment terms with corrected data.

The Parties shall meet to discuss the specific payment provision calculations for the next Performance Year at least 90 days before the start of a Performance Year. If the payment provisions are not acceptable to OneCare or DVHA, either may terminate this agreement for the upcoming Performance Year at any time before December 30th of the year before the Performance Year begins.

D. Payment for Services

1. In accordance with the Attribution Methodology described in Sections 1.0 through and including 1.3.4 of Attachment A of this Agreement, the State is liable to OneCare and OneCare is accountable for an all-inclusive population based payment (hereinafter referred to as AIPBP).

   The Parties agree that the distribution of the AIPBP is set out in Subsection D below.

2. DVHA agrees to pay to OneCare prospectively on a monthly basis a Net AIPBP that includes covered services that are billed by a defined list of ACO-contracted providers for each person that is attributed to OneCare (Fixed Prospective Payment), an administrative fee, and a Primary Care Case Management fee. This payment is set out in column G below.

	A	B=C+D	C	D	E	F	G=D+E+F
MEG	AIPBP	Risk Corridor Benchmark or Expected TCOC	Allocation of FFS	Allocation towards AIPBP or FPP	Administration	PCCM	Monthly Net AIPBP to OCVT
			36.03%	63.97%			
ABD	$616.07	$607.07	$218.73	$388.34	$6.50	$2.50	$397.34
Consolidated Adult	$376.49	$367.49	$132.41	$235.08	$6.50	$2.50	$244.08
Consolidated Child	$120.97	$111.97	$40.34	$71.63	$6.50	$2.50	$80.63

3. In exchange for the payment described in this Section 2, OneCare agrees to the following terms:

A. OneCare will provide the Medicaid covered services described in Sections 3.0 through and including 3.8 (Covered Services) in Attachment A of this Agreement subject to the limitations noted in this Agreement. The medical care and services includes the services more specifically described in Exhibit 1 to Attachment A of this Agreement.

B. In addition to the services provided in paragraph D3(A), OneCare will provide services incurred, but not received to attributed members after termination of the agreement as well as services incurred but not received prior to termination. As an example, an attributed member has a five (5) day hospital stay that spans both before and after the termination of the contract. The incurred, but not received services are those provided to the attributed members after the termination date.

4. The Parties agree that OneCare has received a Readiness Review prior to commencement of the performance of this Agreement. The Parties agree that a Readiness Review is a multi-day operational review by DVHA officials of OneCare that is provided on site at OneCare. The purpose of the review is to determine whether OneCare has the structure, staff and technology capable of performing Accountable Care Organizational Services required in this contract.

As detailed in the Readiness Review report, the DVHA Review Team scored 74% of the review items as fully met, 23% as partially met and 3% as not met. Among the items deemed partially met or not met, however, the DVHA Review Team in consultation with OneCare has determined a path forward for OneCare to achieve fully met status on all items within the first quarter of Calendar Year 2017. OneCare completed all remaining items in the Readiness Review prior to March 31, 2017.

5. OneCare agrees to ongoing monitoring and completion of the assessment of the Readiness Review. DVHA may, in its sole discretion, allow OneCare flexibility in the successful completion of some functions of the Accountable Care Organization if such tasks are not necessary to be functional on January 1, 2017.

a. For example, DVHA may provide that some reporting functions may be required to be functional later than January 1, 2017. However, DVHA would not allow OneCare to provide an adequate provider network to be functioning after January 1, 2017.

6. As provided in Section 9.0 of Attachment A of this Agreement, the State will provide an ACO Reporting Manual. OneCare agrees to provide the reports provided for in such manual subject to the conditions set forth in Attachment A.

7. OneCare agrees to comply with the definitions found in Section 10.1 of Attachment A of this Agreement as well as the Information System Responsibilities of Section 10.2 and the Privacy and Security Practices of Section 10.3 and the Disaster Recovery Plan in Section 10.3.1 of Attachment A of this Agreement. DVHA may test the compliance with these requirements in the Readiness Review described in Section three (3) above.

8. OneCare agrees to comply with the data file exchange requirements of Section 10.4 through and including 10.5 of Attachment A of this Agreement.

E. DISTRIBUTION OF AIPBP

1. DVHA agrees to pay the AIPBP generally in two parts. It will pay part of the AIPBP, defined as NET AIPBP, directly to OneCare. DVHA also agrees to pay part of the AIPBP to Medicaid providers who treat attributed members. This payment will be made from DVHA to the provider and payment will be made based upon the current approved Medicaid fee for service fee schedule without regard to the monthly AIPBP established in column A of the chart on Page 81 of Attachment A.

2. Effective February 1, 2017, DVHA agrees to directly pay OneCare a prospective monthly dollar value of column G above (Net AIPBP) times the number of attributed lives in each MEG. For example, if there are 10,000 members in each MEG, DVHA would pay the following:

   10,000 times $397.34= $3,973,400.00
   10,000 times $244.08= $2,440,800.00
   10,000 times $80.63= $ 806,300.00
   Total each month= $7,220,500.00

3. DVHA agrees to pay providers the fee-for-service fee schedule for claims by provider who treat attributed members. All of these payments are part of the AIPBP. Not all are paid directly to OneCare but paid directly to providers for FFS claims filed with DVHA. The Parties agree that Column C above represents the estimated value of potential fee for service payments from the AIPBP.

4. The Parties agree and recognize that total payments made under columns C and G from month to month, may exceed AIPBP. This value, whether above or below the total value of column A (the AIPBP), is subject to an annual reconciliation and the risk corridor agreements set out below.

5. **Hospital Payments in January 2017**: The following terms apply only to payments made by DVHA in January 2017.

   Due to the late timing in getting the financial and other contract terms finalized, DVHA will pay claims for OneCare attributed beneficiaries under existing reimbursement terms for claims with dates of service between January 1, 2017 and January 31, 2017. DVHA will reconcile the payments made for claims with January 2017 dates of services against the sums in Column D multiplied by the number of member months in each MEG for January, and the following adjustments to payments will be made:

   a. If the January actual payments on a PMPM basis to the participating hospitals are greater than the 2017 FPP (allocation towards AIPBP Column D), then the December 2017 Net AIPBP to OneCare (Column G) will be decreased by the amount of the January actual payments on a PMPM basis minus Column D multiplied by the number of January 2017 actual PMPM payments member months in each MEG.

b. If the January actual payments on a PMPM basis to the participating hospitals are less than the 2017 FPP (allocation towards AIPBP, Column D), then the December 2017 Net AIPBP to OneCare (Column G) will be increased by the amount of the January actual payments plus Column D multiplied by the number of member months in each MEG.

Timing: The January actual payments to each participating hospital will be calculated after claims run-out through September 2017 with a relevant actuarial completion factor added for purposes of the above reconciliation, and if necessary the resulting payment adjustment will be made in the December 2017 Net AIPBP payment.

Examples:

Example A – Participating Hospitals' January actual payments are $6.5 Million, and Monthly FPP (allocation towards AIPBP, Column D) is $6 Million then DVHA reduces Net AIPBP (Column G) for December 2017 by $500,000.

Example B – Participating Hospitals' January actual payments are $5.5 Million, and Monthly FPP (allocation towards AIPBP, Column D) is $6 Million then DVHA increases Net AIPBP (Column G) for December 2017 by $500,000.

6. The parties agree that there will be payment for the administrative component to the contract that does not count towards the expected or actual total cost of care. OneCare shall report to DVHA quarterly on the distribution of and the activities supported by Administrative Funding as outlined below. Additionally, DVHA may monitor the distribution of Administrative Funds in accordance with Section 2.16 of Attachment A.
    a. The total administrative PMPM payment, payable from January 1, 2017, shall be $6.50 and shall be distributed by OneCare in the following manner:
        i. Administrative payment retained by OneCare: $3.25 PMPM.
        ii. Administrative payment for distribution to network providers: $3.25 PMPM.
    b. Administrative payment distributed to OneCare to pay for 2017 Health Information Technology Innovation for its providers, as described in section 7.5 of Attachment A of this contract and payable from October 1, 2017: $1,500,000 for the 2017 Program Year.
    c. Administrative payment paid to providers meeting program and contractual criteria for OneCare's 2017 Advanced Community Care Coordination Model, as described in section 7.6 of Attachment A of this contract and payable from October 1, 2017: $1,307,983 for the 2017 Program Year.

For payment for the administrative components for Health Information Technology Innovation (Attachment B, Section E.6(b)) and the Advanced Community Care Coordination Model (Attachment B, Section E.6(c)), OneCare shall submit invoices quarterly on October 15, 2017 and January 15, 2018 in conjunction with the deliverables specified in Attachment A, Sections 7.5 and 7.6. Quarterly payments will be contingent upon DVHA's receipt and approval of the quarterly deliverables specified in Attachment A, Sections 7.5 and 7.6. The Payment Schedule tables below detail the months in 2017 in which OneCare will conduct the activities specified in Attachment A, Sections 7.5 and 7.6 to achieve the overarching Goals for Health Information Technology Innovation and the Advanced Communicy Care Coordination Model.

Health Information Technology Administrative Funding (Attachment A; Section 7.5) – 2017 Payment Schedule							
	3rd Quarter			**4th Quarter**			
Activities in support of Goal Achievement	Jul - 17	Aug- 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	***TOTAL***
Section 7.5 - Goal 1: WorkbenchOne (WBO) and Care Navigator							
1. Create an application to monitor utilization of services and identify trends of over- or under-utilization where intervention may be indicated	*	*	*	*	*	*	
2. Create an application for risk bearing providers to monitor financial goals against contract targets	*	*	*	*	*	*	
3. Create an All Payer Model Quality Measure scorecard report, to ensure ongoing monitoring of quality measure performance throughout the year	*	*	*	*	*	*	
4. Integrate inpatient and emergency room event notification into Care Navigator in order to support complex care coordination	*	*	*	*	*	*	
5. Develop a Care Coordination Effectiveness & Outcomes Analysis framework to monitor program effectiveness and inform program changes or enhancements	*	*	*	*	*	*	
6. Analyze Clinical Data Quality Reporting, to identify the areas where clinical data from source systems or VITL are not available to perform automated quality measurement	*	*	*	*	*	*	
Section 7.5 - Goal 2: Training and Technical Assistance on Advanced Analytics							
1. Provide training and technical assistance to the network on the interpretation of under/over utilization trends and financial trends against targets	*	*	*	*	*	*	
2. Provide training and technical assistance to the network on quality measures and performance against targets (based on available claims data)	*	*	*	*	*	*	
3. Develop training materials/workflows for care coordinators in the use of event notification	*	*	*	*	*	*	
Section 7.5 – GOALS 1 & 2 QUARTERLY PAYMENTS		**$ 750,000.00**			**$ 750,000.00**		***$ 1,500,000.00***

*Denotes month in which Contractor will perform work for specified activity in support of demonstrating achievement of goal.

Advanced Community Care Coordination (A3C) Administrative Funding (Attachment A; Section 7.6) – 2017 Payment Schedule							
	3rd Quarter			**4th Quarter**			
Activities in support of Goal Achievement	Jul - 17	Aug- 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	***TOTAL***
Section 7.6 - Goal 1: Support Effective Team Based Care Coordination at the Local Level							
1. Develop and refine team based care coordination protocols between primary care medical home (PCMH) and continuum of care providers	*	*	*	*	*	*	
2. Provide training and technical assistance on risk stratification and care coordination core competencies that support person centered care	*	*	*				
3. Provide training on expectations for team-based care-coordination, and support in the use of Care Navigator to complete person-centered shared care plans	*	*	*				
4. Develop and deploy care coordination best practices and lessons learned across current VMNG communities via monthly cross-community care coordination team meetings	*	*	*				
5. Evaluate, and refine if necessary, care coordination protocols to support the care model	*	*	*	*	*	*	
6. Develop a plan to evaluate existing care coordination competencies and address identified gaps in local knowledge and/or skill				*	*	*	
7. Measure consistent use of shared care plans across sites				*	*	*	
8. Convene PCMH staff, Blueprint for Health staff and community agencies, representing the continuum of care, to make recommendations on how to refine the care model in order to allow it to be sustainable with population growth				*	*	*	
9. Develop a planning roadmap for expansion to additional populations				*	*	*	
10. Provide community capacity payment in each risk-based community in partnership with the Blueprint for Health		*					
11. Provide ongoing PMPM to primary care, home health, designated agencies and area agencies on aging for engaging in a team-based approach to coordinating care	*	*	*	*	*	*	
Section 7.6 - Goal 2: Develop a framework that will capture the value/impact of care coordination activities							
1. Establish work groups across sites designed to support development and adoption of framework	*	*	*				
2. Provide for ongoing PMPM to one lead care coordinator activating and engaging	*	*	*	*	*	*	

attributed members in a shared care plan							
3. Provide for a one-time payment annually to one lead care coordinator for activating and engaging attributed members in a shared care plan	*	*	*	*	*	*	
4. Identify key metrics to track the value/impact at the systems and local level	*	*	*				
5. Build a dashboard in Care Navigator to display key metrics that will be evaluated on an ongoing basis	*	*	*				
6. Evaluate data to identify early indicators of success				*	*	*	
Section 7.6 – GOAL 1 QUARTERLY PAYMENTS			$ 605,655.00			$ 455,653.00	*$ 1,061,308.00*
Section 7.6 – GOAL 2 QUARTERLY PAYMENTS			$ 123,337.50			$ 123,337.50	*$ 246,675.00*
Section 7.6 – GOALS 1 & 2 QUARTERLY PAYMENTS			**$ 728,992.50**			**$ 578,990.50**	***$ 1,307,983.00***

*Denotes month in which Contractor will perform work for specified activity in support of demonstrating achievement of goal.

F. Risk Corridor

1. The Parties agree that the risk corridor benchmark (also referred to as Expected Total Cost of Care) is the AIPBP less the administration fee and PCCM fee (Column B equals column A minus columns E and F in the table above). The Parties agree that the sum in Column B above multiplied by the actual member months in each MEG comprises the benchmark the Parties will use to calculate the risk corridor provisions.

2. Additionally, the Parties agree to a 3% risk sharing (corridor) arrangement as follows:

    a. If, at the time of reconciliation, the Actual Total Cost of Care (ATCOC) is between 100% and 103% of the risk corridor benchmark (or expected total cost of care) amount, OneCare agrees it is liable for the costs between 100% and 103%. To the extent those costs are borne by DVHA during the year, OneCare shall be liable to DVHA.
    b. Conversely, if the Actual Total Cost of Care (ATCOC) is between 97% and 100% of the risk corridor benchmark (or ETCOC) OneCare will be entitled to receive from DVHA all savings associated with costs between 97% and 100%.

3. If during the contract, DVHA determines that the actual fee-for-service (FFS) payments are 15% or more above the allocation of FFS (Column C above) multiplied by the number of member months FFS payments the parties shall meet to discuss the utilization or costs and potential required remedies. The first evaluation of this will occur in the month of May.

G. Reconciliation

1. Year End Reconciliation Process: The Parties agree that year end reconciliation, as defined above, will be conducted in accordance with Section 10.6 of Attachment A of this Agreement using all reports in Section 10.4 through and including 10.4.9.
2. The aggregate gross savings or losses will be determined by subtracting the per member per month Actual TCOC from the per member per month Expected TCOC, then multiplying the result by the

total person months. If the result is positive, there are gross savings; if the result is negative there are gross losses. The gross savings or losses are shared between DVHA and OneCare based on the risk corridor established in this Attachment B.

H. Hold Harmless

If fee for service rates rise or fall for any covered services in this contract, a rate increase has two impacts on this contract. First, the AIPBP will increase or decrease. Second, the risk corridor benchmark or expected total cost of care will need to be increased or decreased. Based upon these issues DVHA will hold OneCare harmless for any material fee for service reimbursement changes implemented during 2017, as follows:

- The AIPBP and Risk Corridor Benchmark or Expected Total Cost of Care will be increased to fully mitigate the impact to OneCare of any fee for service reimbursement increases implemented by the State.
- The AIPBP and Risk Corridor Benchmark or Expected Total Cost of Care will be decreased to fully mitigate the impact to OneCare of any fee for service reimbursement decreases implemented by the State.

I. DISPUTE RESOLUTION PROCESS

1. The Parties agree that to resolve disputes regarding Attachment B, Subsections C, D, E, F, H, and I and the following dispute resolution process shall be followed prior to pursing a remedy from a third party:

a. The issue in dispute will be referred to the ACO Program Director for DVHA, and the individual referred to in Section 7 on page 2 of Attachment A of this Agreement for the Contractor, or their respective designees. Each representative shall consult with the managerial or directorial staff who are routinely tasked with oversight of work concerning the subject matter of the issue in dispute. The Parties shall gather the information they need to evaluate the issue in dispute and will have fourteen (14) business days from the date the issue is referred to resolve the dispute.

b. If the program directors, or individual referred to in Subsection 11 (a) have not resolved the issue in dispute within fourteen (14) business days, the issue will be referred to the Commissioner of the Department of Vermont Health Access, or his/her designee, for the State and to the Chief Executive Officer of the ACO, or his/her designee, for the ACO. The Parties shall gather the information they need to evaluate the issue in dispute and will have thirty (30) business days from the date the issue is referred to resolve the dispute.

c. If the issue is not resolved by the management in subsection (b), within thirty (30) business days from referral, DVHA or the ACO may bring an action for relief in the Washington Civil Division of the Vermont Superior Court. Nothing in this section shall prevent either party from seeking injunctive relief, or any other legal remedy, prior to utilizing the procedure in this section.

J. Quality Incentive Pool Program

1. Program Establishment and Eligibility

DVHA has established the following framework allowing the Contractor to allocate a portion of the All-Inclusive Population-Based Payment to a quality incentive pool that can be used for value-based payments to the Contractor's network providers, for reinvestment into ACO-wide quality improvement

initiatives, or for a combination of the two. The Contractor's ability to use these funds is subject to Contractor's complete and timely satisfaction of its obligations under the Contract. This includes, but is not limited to, timely submission of the Contractor's HEDIS data for the measurement year as well as timely submission of Priority Reports identified by DVHA in the ACO Reporting Manual.
The Contractor may, at DVHA's discretion, lose eligibility for its compensation under the quality incentive pool program if:

a. DVHA has suspended, in whole or in part, capitation payments or attribution to the Contractor;
b. The Contract has been terminated;
c. The Contractor has, in the determination of the DVHA Commissioner, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the Contractor responsibilities set forth in Attachment A; or
d. Pursuant to the Contract including without limitation this Attachment, DVHA has required a corrective action plan that the Contractor has not complied with.

DVHA may, at its option, reinstate Contractor's eligibility for participation in the quality incentive pool program once Contractor has properly corrected all prior instances of non-compliance of its obligations under the Contract, and DVHA has satisfactory assurances of acceptable future performance.

2. Incentive Pool Potential

During each measurement year, the ACO will withhold a portion of the approved AIPBP payments each for the quality incentive pool as follows:

- Calendar Year 2017 – one half percent (0.5%)
- Calendar Year 2018 – one and one half percent (1.5%)
- Calendar Year 2019 – three percent (3.0%)

Contractor agrees to produce a report at year end showing distribution of the Quality Incentive Pool fund.

3. Performance Measures and Incentive Payment Structure

The performance measures, targets and incentive payment opportunities for Calendar Years 2017, 2018, and 2019 are set forth in the tables below. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. The performance measures and targets applicable during subsequent years of the Contract shall be established annually by DVHA and reflected in an amendment to the Contract. Payment measures are measures for which ACO performance will impact the way the quality incentive pool funds may be distributed. Reporting measures are those that the ACO is required to report; however, ACO performance on Reporting measures will not impact the distribution of quality incentive pool funds.

Contractor performance shall be calculated based on care delivered during Calendar Year 2017. Contractor shall submit information to DVHA, in the format and detail specified by DVHA, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment.

Measure	Measure Use	Data Source	National Medicaid Benchmarks Available for 2017 Contract Year
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	Payment*	Claims	No
30 Day Follow-Up after Discharge from the ED for Mental Health	Payment*	Claims	No
Adolescent Well Care Visits	Payment	Claims	Yes
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Payment*	Claims	No
Developmental Screening in the First 3 Years of Life	Payment	Claims OR Clinical	No^
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	Payment	Clinical	Yes
Hypertension: Controlling High Blood Pressure	Payment	Clinical	Yes
Initiation of Alcohol and Other Drug Dependence Treatment	Payment	Claims	Yes
Engagement of Alcohol and Other Drug Dependence Treatment	Payment	Claims	Yes
Screening for Clinical Depression and Follow-Up Plan	Payment*	Claims and Clinical	No
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	Reporting	Claims	Yes
Timeliness of Prenatal Care	Reporting	Claims	Yes

* Award full credit if appropriate benchmarks cannot be identified for 2017 contract year performance

^ Multi-state benchmark available; not National

a. Each Payment Measure will carry equal weight in the scoring methodology; Reporting measures will not be scored.
b. The Contractor's quality performance in each calendar year will be compared to national (or multi-state) Medicaid percentile benchmarks, and each measure will be scored individually.
c. The Contractor may earn up to 2 points per measure for attainment relative to national (or multi-state) benchmarks. Beginning in the second year (2018), the Contractor may earn points for improvement over the prior year's performance.
d. The total possible points will be calculated as the number of payment measures multiplied by a maximum of 2 points per Payment Measure; the Contractor may not earn more than the total possible points for attainment and improvement combined.
e. As national (or multi-state) benchmarks will not be available for the 2017 Performance Year for certain Payment Measures (denoted by * in the table above), the Contractor will be granted full credit for Reporting those measures in 2017.
f. DVHA will make its best efforts to distribute a report identifying Contractor's performance during Calendar Year 2017 and the amount of incentive payments, if any, earned for each outcome measure identified in Section 3 by April 1, 2018.

	2017	2018	2019
% of AIPBP Allocated to Quality Incentive Pool	0.5%	1.5%	3.0%

Total Possible Points	20	20	20
Points Awarded for Reporting	8	0	0
Improvement Points Available	No	Yes	Yes

National (or Multi-State) Benchmark	2017 Points Awarded	2018 Points Awarded	2019 Points Awarded
90th+ percentile			2
75th+ percentile	2	2	1.5
50th+ percentile	1.5	1	1
25th+ percentile	1	0.5	0.5
<25th percentile	0	0	0

g. The Contractor shall distribute quality incentive pool funds to network providers using a methodology (and quality measures appropriate for provider comparison) of their choosing, subject to approval from DVHA. Contractor shall annually provide a proposed methodology for approval prior to the end of the performance year. Such approval shall be granted or denied within thirty (30) days of submission to the contract monitor.

h. Any portion of quality funds not distributed to network providers based on quality performance shall be reinvested into ongoing quality improvement initiatives using an approach mutually agreed upon by the ACO and DVHA.

i. The proportion available for allocation to network providers shall be determined by the overall quality score; the remainder shall be reinvested, per the tables for 2017, 2018, and 2019 below.

2017		
Earned Points (Max. **20**)	Share of Quality Payment Available for Distribution to Network Providers	Share of Quality Payment Available for Reinvestment in QI Initiatives
0	0.0000%	0.5000%
0.5	0.0125%	0.4875%
1	0.0250%	0.4750%
1.5	0.0375%	0.4625%
2	0.0500%	0.4500%
2.5	0.0625%	0.4375%
3	0.0750%	0.4250%
3.5	0.0875%	0.4125%
4	0.1000%	0.4000%
4.5	0.1125%	0.3875%
5	0.1250%	0.3750%
5.5	0.1375%	0.3625%
6	0.1500%	0.3500%
6.5	0.1625%	0.3375%
7	0.1750%	0.3250%
7.5	0.1875%	0.3125%
8	0.2000%	0.3000%
8.5	0.2125%	0.2875%
9	0.2250%	0.2750%

9.5	0.2375%	0.2625%
10	0.2500%	0.2500%
10.5	0.2625%	0.2375%
11	0.2750%	0.2250%
11.5	0.2875%	0.2125%
12	0.3000%	0.2000%
12.5	0.3125%	0.1875%
13	0.3250%	0.1750%
13.5	0.3375%	0.1625%
14	0.3500%	0.1500%
14.5	0.3625%	0.1375%
15	0.3750%	0.1250%
15.5	0.3875%	0.1125%
16	0.4000%	0.1000%
16.5	0.4125%	0.0875%
17	0.4250%	0.0750%
17.5	0.4375%	0.0625%
18	0.4500%	0.0500%
18.5	0.4625%	0.0375%
19	0.4750%	0.0250%
19.5	0.4875%	0.0125%
20	0.5000%	0.0000%

2018		
Earned Points (Max. **20**)	Share of Quality Payment Available for Distribution to Network Providers	Share of Quality Payment Available for Reinvestment in QI Initiatives
0	0.0000%	1.5000%
0.5	0.0375%	1.4625%
1	0.0750%	1.4250%
1.5	0.1125%	1.3875%
2	0.1500%	1.3500%
2.5	0.1875%	1.3125%
3	0.2250%	1.2750%
3.5	0.2625%	1.2375%
4	0.3000%	1.2000%
4.5	0.3375%	1.1625%
5	0.3750%	1.1250%
5.5	0.4125%	1.0875%
6	0.4500%	1.0500%
6.5	0.4875%	1.0125%
7	0.5250%	0.9750%
7.5	0.5625%	0.9375%
8	0.6000%	0.9000%

8.5	0.6375%	0.8625%
9	0.6750%	0.8250%
9.5	0.7125%	0.7875%
10	0.7500%	0.7500%
10.5	0.7875%	0.7125%
11	0.8250%	0.6750%
11.5	0.8625%	0.6375%
12	0.9000%	0.6000%
12.5	0.9375%	0.5625%
13	0.9750%	0.5250%
13.5	1.0125%	0.4875%
14	1.0500%	0.4500%
14.5	1.0875%	0.4125%
15	1.1250%	0.3750%
15.5	1.1625%	0.3375%
16	1.2000%	0.3000%
16.5	1.2375%	0.2625%
17	1.2750%	0.2250%
17.5	1.3125%	0.1875%
18	1.3500%	0.1500%
18.5	1.3875%	0.1125%
19	1.4250%	0.0750%
19.5	1.4625%	0.0375%
20	1.5000%	0.0000%

2019		
Earned Points (Max. **20**)	Share of Quality Payment Available for Distribution to Network Providers	Share of Quality Payment Available for Reinvestment in QI Initiatives
0	0.000%	3.000%
0.5	0.075%	2.925%
1	0.150%	2.850%
1.5	0.225%	2.775%
2	0.300%	2.700%
2.5	0.375%	2.625%
3	0.450%	2.550%
3.5	0.525%	2.475%
4	0.600%	2.400%
4.5	0.675%	2.325%
5	0.750%	2.250%
5.5	0.825%	2.175%
6	0.900%	2.100%
6.5	0.975%	2.025%
7	1.050%	1.950%

7.5	1.125%	1.875%
8	1.200%	1.800%
8.5	1.275%	1.725%
9	1.350%	1.650%
9.5	1.425%	1.575%
10	1.500%	1.500%
10.5	1.575%	1.425%
11	1.650%	1.350%
11.5	1.725%	1.275%
12	1.800%	1.200%
12.5	1.875%	1.125%
13	1.950%	1.050%
13.5	2.025%	0.975%
14	2.100%	0.900%
14.5	2.175%	0.825%
15	2.250%	0.750%
15.5	2.325%	0.675%
16	2.400%	0.600%
16.5	2.475%	0.525%
17	2.550%	0.450%
17.5	2.625%	0.375%
18	2.700%	0.300%
18.5	2.775%	0.225%
19	2.850%	0.150%
19.5	2.925%	0.075%
20	3.000%	0.000%

K. Liquidated Damages

1. OneCare agrees that following liquidated damages will be paid in the event OneCare fails to comply with the reporting and data file transfer requirements of Section 9 and Section 10.4 of Attachment A. OneCare agrees that the failure by the Contractor to provide timely and accurate reports required by this contract, will cause the State to suffer damages which are difficult to estimate. Each party represents, after all diligence it has determined appropriate, that the liquidated damages set forth below ("Liquidated Damages") are reasonable estimates of the damages which the State will suffer and are compensation for untimely reports and damages which are difficult to accurately determine.

   a. For the failure to provide timely Member & Provider Service Reports as required by Section 9.1.2 of Attachment A, an amount of $400.00 per reporting period. The intended periodicity of these reports is submission 30 days after each calendar quarter of the year.

   b. For the failure to meet service level performance of the Member Service Helpline as required by Section 4.3.1of Attachment A, an amount of $1,500.00 per month.

   c. For the failure to provide timely information regarding the ACO affiliated provider file as required by Section 10.4.1 in Attachment A, an amount of $5,000.00 per month. The intended periodicity of this file submission is weekly.

d. For the failure to provide accurate information regarding the ACO affiliated provider file as required by Section 10.4.1 in Attachment A, an amount of $2,500.00.

e. For the failure to provide timely information system reports regarding the ACO Case Management File as required by Section 10.4.9 in Attachment A, an amount of $500.00 per month. The intended periodicity of this file submission is monthly.

2. DVHA agrees that no liquidated damage will be assessed for the failure of reporting prior to February 1, 2017.

3. The Parties agree that while liquidated damages may be assessed as provided for above, such assessment of damages do not prevent DVHA from requiring a corrective action plan regarding deficiencies regarding reporting.

4. If any Liquidated Damages are held to be unenforceable, then such Liquidated Damages shall be deemed deleted from this Contract, and DVHA shall have the right to recover such damages as it is legally able to recover under this Contract.

5. Liquidated damages shall be assessed by letter with reasoning by DVHA. The Parties agree that liquidated damages may be withheld from the capitation payment made monthly from DVHA to the Contractor subject to the dispute resolution clause below. DVHA's decision not to immediately withhold capitation payment shall not be construed as a waiver of the right to liquidated damages.

6. To the extent that DVHA's or any of its agents delay in providing information or there is inaccuracy in the information provided to OneCare that causes or contributes to causing OneCare to have a late or inaccurate reports the time limits for any reporting (including those in Section 9 of Attachment A of this Agreement) shall be tolled until the DVHA or agent's delay or inaccuracy is cured.

ATTACHMENT C: STANDARD STATE PROVISIONS FOR CONTRACTS AND GRANTS (Restated)
REVISED JULY 1, 2016

1. Definitions: For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement. "Agreement" shall mean the specific contract or grant to which this form is attached.

2. Entire Agreement: This Agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

3. Governing Law, Jurisdiction and Venue; No Waiver of Jury Trial: This Agreement will be governed by the laws of the State of Vermont. Any action or proceeding brought by either the State or the Party in connection with this Agreement shall be brought and enforced in the Superior Court of the State of Vermont, Civil Division, Washington Unit. The Party irrevocably submits to the jurisdiction of this court for any action or proceeding regarding this Agreement. The Party agrees that it must first exhaust any applicable administrative remedies with respect to any cause of action that it may have against the State with regard to its performance under the Agreement.

Party agrees that the State shall not be required to submit to binding arbitration or waive its right to a jury trial.

4. Sovereign Immunity: The State reserves all immunities, defenses, rights or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution. No waiver of the State's immunities, defenses, rights or actions shall be implied or otherwise deemed to exist by reason of the State's entry into this Agreement.

5. No Employee Benefits For Party: The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. Independence: The Party will act in an independent capacity and not as officers or employees of the State.

7. Defense and Indemnity: The Party shall defend the State and its officers and employees against all third party claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party in connection with the performance of this Agreement. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The State retains the right to participate at its own expense in the defense of any claim. The State shall have the right to approve all proposed settlements of such claims or suits. In the event the State withholds approval to settle any such claim, then the Party shall proceed with the defense of the claim but under those circumstances, the Party's indemnification obligations shall be limited to the amount of the proposed settlement initially rejected by the State.

After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party in connection with the performance of this Agreement.

The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party or an agent of the Party in connection with the performance of this Agreement.

The Party agrees that in no event shall the terms of this Agreement nor any document required by the Party in connection with its performance under this Agreement obligate the State to defend or indemnify the Party or otherwise be liable for the expenses or reimbursement, including attorneys' fees, collection costs or other costs of the Party except to the extent awarded by a court of competent jurisdiction.

8. Insurance: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverages are in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the State through the term of the Agreement. No warranty is made that the coverages and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont. Vermont will accept an out-of-state employer's workers' compensation coverage while operating in Vermont provided that the insurance carrier is licensed to write insurance in Vermont and an amendatory endorsement is added to the policy adding Vermont for coverage purposes. Otherwise, the party shall secure a Vermont workers' compensation policy, if necessary to comply with Vermont law.

General Liability and Property Damage: With respect to all operations performed under this Agreement, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

Premises - Operations

Products and Completed Operations

Personal Injury Liability

Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

$1,000,000 Each Occurrence

$2,000,000 General Aggregate

$1,000,000 Products/Completed Operations Aggregate

$1,000,000 Personal & Advertising Injury

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than $500,000 combined single limit. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, limits of coverage shall not be less than $1,000,000 combined single limit.

Additional Insured. The General Liability and Property Damage coverages required for performance of this Agreement shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, then the required Automotive Liability coverage shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

Notice of Cancellation or Change. There shall be no cancellation, change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) without thirty (30) days written prior written notice to the State.

9. Reliance by the State on Representations: All payments by the State under this Agreement will be made in reliance upon the accuracy of all representations made by the Party in accordance with the Contract, including but not limited to bills, invoices, progress reports and other proofs of work.

10. False Claims Act: The Party acknowledges that it is subject to the Vermont False Claims Act as set forth in 32 V.S.A. § 630 *et seq.* If the Party violates the Vermont False Claims Act it shall be liable to the State for civil penalties, treble damages and the costs of the investigation and prosecution of such violation, including attorney's fees, except as the same may be reduced by a court of competent jurisdiction. The Party's liability to the State under the False Claims Act shall not be limited notwithstanding any agreement of the State to otherwise limit Party's liability.

11. Whistleblower Protections: The Party shall not discriminate or retaliate against one of its employees or agents for disclosing information concerning a violation of law, fraud, waste, abuse of authority or acts threatening health or safety, including but not limited to allegations concerning the False Claims Act. Further, the Party shall not require such employees or agents to forego monetary awards as a result of such disclosures, nor should they be required to report misconduct to the Party or its agents prior to reporting to any governmental entity and/or the public.

12. Federal Requirements Pertaining to Grants and Subrecipient Agreements:

A. **Requirement to Have a Single Audit:** In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a Single Audit is required for the prior fiscal year. If a Single Audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required.

   For fiscal years ending before December 25, 2015, a Single Audit is required if the subrecipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. For fiscal years ending on or after December 25, 2015, a Single Audit is required if the subrecipient expends $750,000 or more in federal assistance during its fiscal year and must be conducted in accordance with 2 CFR Chapter I, Chapter II, Part 200, Subpart F. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a Single Audit is required.

B. **Internal Controls:** In the case that this Agreement is a Grant that is funded in whole or in part by Federal funds, in accordance with 2 CFR Part II, § 200.303, the Party must establish and maintain effective internal control over the Federal award to provide reasonable assurance that the Party is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States and the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

C. **Mandatory Disclosures:** In the case that this Agreement is a Grant funded in whole or in part by Federal funds, in accordance with 2CFR Part II, §200.113, Party must disclose, in a timely manner, in writing to the State, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures may result in the imposition of sanctions which may include disallowance of costs incurred, withholding of payments, termination of the Agreement, suspension/debarment, etc.

13. Records Available for Audit: The Party shall maintain all records pertaining to performance under this agreement. "Records" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired by the Party in the performance of this agreement. Records produced or acquired in a machine readable electronic format shall be maintained in that format. The records described shall be made

available at reasonable times during the period of the Agreement and for three years thereafter or for any period required by law for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved.

14. Fair Employment Practices and Americans with Disabilities Act: Party agrees to comply with the requirement of 21 V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement.

15. Set Off: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

16. Taxes Due to the State:

A. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

B. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

C. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

D. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

17. Taxation of Purchases: All State purchases must be invoiced tax free. An exemption certificate will be furnished upon request with respect to otherwise taxable items.

18. Child Support: (Only applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she:

A. is not under any obligation to pay child support; or

B. is under such an obligation and is in good standing with respect to that obligation; or

C. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

19. Sub-Agreements: Party shall not assign, subcontract or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party shall be responsible and liable to the State for all acts or omissions of subcontractors and any other person performing work under this Agreement pursuant to an agreement with Party or any subcontractor.

In the case this Agreement is a contract with a total cost in excess of $250,000, the Party shall provide to the State a list of all proposed subcontractors and subcontractors' subcontractors, together with the identity of those subcontractors' workers compensation insurance providers, and additional required or requested information, as applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54).

Party shall include the following provisions of this Attachment C in all subcontracts for work performed solely for the State of Vermont and subcontracts for work performed in the State of Vermont: Section 10 ("False Claims Act"); Section 11 ("Whistleblower Protections"); Section 14 ("Fair Employment Practices and Americans with Disabilities Act"); Section 16 ("Taxes Due the State"); Section 18 ("Child Support"); Section 20 ("No Gifts or Gratuities"); Section 22 ("Certification Regarding Debarment"); Section 23 ("Certification Regarding Use of State Funds"); Section 31 ("State Facilities"); and Section 32 ("Location of State Data").

20. No Gifts or Gratuities: Party shall not give title or possession of anything of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

21. Copies: Party shall use reasonable best efforts to ensure that all written reports prepared under this Agreement are printed using both sides of the paper.

22. Certification Regarding Debarment: Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing/debarment

23. Certification Regarding Use of State Funds: In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

24. Conflict of Interest: Party shall fully disclose, in writing, any conflicts of interest or potential conflicts of interest.

25. Confidentiality: Party acknowledges and agrees that this Agreement and any and all information obtained by the State from the Party in connection with this Agreement are subject to the State of Vermont Access to Public Records Act, 1 V.S.A. § 315 et seq.

26. Force Majeure: Neither the State nor the Party shall be liable to the other for any failure or delay of performance of any obligations under this Agreement to the extent such failure or delay shall have been wholly or principally caused by acts or events beyond its reasonable control rendering performance illegal or impossible (excluding strikes or lock-outs) ("Force Majeure"). Where Force Majeure is asserted, the nonperforming party must prove that it made all reasonable efforts to remove, eliminate or minimize such cause of delay or damages, diligently pursued performance of its obligations under this Agreement, substantially fulfilled all non-excused obligations, and timely notified the other party of the likelihood or actual occurrence of an event described in this paragraph.

27. Marketing: Party shall not refer to the State in any publicity materials, information pamphlets, press releases, research reports, advertising, sales promotions, trade shows, or marketing materials or similar communications to third parties except with the prior written consent of the State.

28. Termination: In addition to any right of the State to terminate for convenience, the State may terminate this

Agreement as follows:

A. **Non-Appropriation:** If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority. In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, and in the event federal funds become unavailable or reduced, the State may suspend or cancel this Grant immediately, and the State shall have no obligation to pay Subrecipient from State revenues.

B. **Termination for Cause:** Either party may terminate this Agreement if a party materially breaches its obligations under this Agreement, and such breach is not cured within thirty (30) days after delivery of the non-breaching party's notice or such longer time as the non-breaching party may specify in the notice.

C. **No Implied Waiver of Remedies:** A party's delay or failure to exercise any right, power or remedy under this Agreement shall not impair any such right, power or remedy, or be construed as a waiver of any such right, power or remedy. All waivers must be in writing.

29. Continuity of Performance: In the event of a dispute between the Party and the State, each party will continue to perform its obligations under this Agreement during the resolution of the dispute until this Agreement is terminated in accordance with its terms.

30. Termination Assistance: Upon nearing the end of the final term or termination of this Agreement, without respect to cause, the Party shall take all reasonable and prudent measures to facilitate any transition required by the State. All State property, tangible and intangible, shall be returned to the State upon demand at no additional cost to the State in a format acceptable to the State.

31. State Facilities: If the State makes space available to the Party in any State facility during the term of this Agreement for purposes of the Party's performance under this Agreement, the Party shall only use the space in accordance with all policies and procedures governing access to and use of State facilities which shall be made available upon request. State facilities will be made available to Party on an "AS IS, WHERE IS" basis, with no warranties whatsoever.

32. Location of State Data: No State data received, obtained, or generated by the Party in connection with performance under this Agreement shall be processed, transmitted, stored, or transferred by any means outside continental United States, except with the express written permission of the State.

(Revised 7/1/16 - End of Standard Provisions)

ATTACHMENT D
MODIFICATION OF CUSTOMARY PROVISIONS
OF
ATTACHMENT C OR ATTACHMENT F (Restated)

1. The insurance requirements contained in Attachment C, Section 8 are amended to add:

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Professional Liability: Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of *$2,000,000* per occurrence, and *$6,000,000* aggregate.

2. Requirements of other Sections in Attachment C are hereby modified:

Sections 17, 18, and 28 B. are hereby deleted.

3. Requirements of Sections in Attachment F are hereby modified:

a. OneCare agrees to the provisions of 45 CFR § 95.617 governing intellectual property ownership. Without restating the regulation, DVHA has all rights in software or modifications associated for any software designed developed or installed with federal financial participation as works for hire. However, it has no rights in proprietary software or its modification.

4. Additional Modifications

a. Notwithstanding anything to the contrary herein, DVHA's Readiness Assessment and approval of Contractor's readiness to perform under this Agreement shall constitute formal and binding recognition by DVHA that Contractor's ACO operations, systems, policies and procedures meet the terms of this Agreement at the time of the readiness review.

b. No later than January 1, 2018, OneCare shall comply with all provisions of federal law related to waivers of fraud and abuse law in connection with the Next Generation ACO model. Specifically, no later than January 1, 2018 OneCare shall comply with Notice of Waiver of Certain Fraud and Abuse Laws in connection with the Next Generation ACO Model dated December 9, 2015 (the 2015 Notice), the Notice of Amended Waivers of Certain Fraud and Abuse Laws in Connection with the Next Generation ACO Model issued on December 29, 2016, and any superseding notice issued by CMS.

Nothing in this agreement shall limit the State of Vermont's right to establish Vermont specific conditions related to fraud and abuse for participation in this ACO program that differ from, or are in addition to, the conditions set forth by CMS for certain fraud and abuse laws in connection with the Next Generation ACO model. Vermont shall provide OneCare with written notice of any Vermont specific conditions related to fraud and abuse waiver in writing 90 days prior to their effect.

The State of Vermont does not intend to prohibit conduct that would be permissible under Federal waiver and agrees that conduct that is permissible under the aforementioned next generation waiver of the Stark Act and Anti Kickback statutes is not inconsistent with State law. The State agrees that prior to January 1, 2018, the State does not view applicable state fraud and abuse laws as restricting conduct that is permitted under federal law, and, to the extent OneCare and its network acts consistently with federal law and guidance related to the specific fraud and abuse waivers issued by CMS for the Next Generation ACO Program, the contractor has not violated State law in so doing. Robust Program Integrity functions have been agreed to by OneCare in Section 11 of Attachment A of this contract. Moreover, the Parties agree that DVHA will continue to perform its Program Integrity functions of OneCare providers as provided by law. Nothing in this agreement shall preclude the State of Vermont from enforcing fraud and abuse law for behavior that is inconsistent with, or outside the scope of, the federal law and guidance related to the Next Generation Program.

5. **Reasons for Modifications:**
Modifications under section one are to comply with the terms of the contract, those under section 2 are not necessary because the Contractor is a Corporate entity, those under section 3 are required for conformity with Federal law.

APPROVAL:

e-Signed by Anna Cykon
on 2017-09-27 13:55:56 GMT

ASSISTANT ATTORNEY GENERAL

DATE: September 27, 2017

State of Vermont – Attachment D
Revised AHS – 10-30-2010

ATTACHMENT E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between the State of Vermont Agency of Human Services, operating by and through its Department of Vermont Health Access ("Covered Entity") and OneCare Vermont Accountable Care Organization, LLC ("Business Associate") as of September 1, 2017 ("Effective Date"). This Agreement supplements and is made a part of the contract/grant to which it is attached.

Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. **Definitions**. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations.

"Agent" means those person(s) who are agents(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

"Breach" means the acquisition, access, use or disclosure of protected health information (PHI) which compromises the security or privacy of the PHI, except as excluded in the definition of Breach in 45 CFR § 164.402.

"Business Associate shall have the meaning given in 45 CFR § 160.103.

"Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"Protected Health Information" or PHI shall have the meaning given in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Agency.

"Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

"Services" includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR § 160.103 under the definition of Business Associate.

"Subcontractor" means a person or organization to whom a Business Associate delegates a function, activity or service, other than in the capacity of a member of the workforce of the Business Associate. For purposes of this Agreement, the term Subcontractor includes Subgrantees.

2. **Identification and Disclosure of Privacy and Security Offices.** Business Associate and Subcontractors shall provide, within ten (10) days of the execution of this agreement, written notice to the Covered Entity's contract/grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer. This information must be updated any time either of these contacts changes.

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying grant or contract with Covered Entity. The uses and disclosures of Business Associate are limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the underlying agreement. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

3.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents and Subcontractors in accordance with Sections 9 and 18 or, (b) as otherwise permitted by Section 3.

3.3 Business Associate shall be directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Covered Entity, and for impermissible uses and disclosures, by Business Associate's Subcontractor(s), of the PHI that Business Associate handles on behalf of Covered Entity and that it passes on to Subcontractors.

4. Business Activities. Business Associate may use PHI received in its capacity as a Business Associate to Covered Entity if necessary for Business Associate's proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as Business Associate to Covered Entity for Business Associate's proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the Agreement requires the person or entity to notify Business Associate, within two (2) business days (who in turn will notify Covered Entity within two (2) business days after receiving notice of a Breach as specified in Section 6.1), in writing of any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in Section 3 must be of the minimum amount of PHI necessary to accomplish such purposes.

5. Safeguards. Business Associate, its Agent(s) and Subcontractor(s) shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate or its Subcontractor(s) shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate or its Agent(s) and Subcontractor(s) shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

6. Documenting and Reporting Breaches.

6.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI, including Breaches reported to it by a Subcontractor, as soon as it (or any of its employees or agents) becomes aware of any such Breach, and in no case later than two (2) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

6.2 Business Associate shall provide Covered Entity with the names of the individuals whose

Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR § 164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it. Business Associate shall require its Subcontractor(s) to agree to these same terms and conditions.

6.3 When Business Associate determines that an impermissible acquisition, use or disclosure of PHI by a member of its workforce is not a Breach, as that term is defined in 45 CFR § 164.402, and therefore does not necessitate notice to the impacted individual(s), it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity. It shall also provide Covered Entity with 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the PHI had been compromised. When a breach is the responsibility of a member of its Subcontractor's workforce, Business Associate shall either 1) conduct its own risk assessment and draft a summary of the event and assessment or 2) require its Subcontractor to conduct the assessment and draft a summary of the event. In either case, Business Associate shall make these assessments and reports available to Covered Entity.

6.4 Business Associate shall require, by contract, a Subcontractor to report to Business Associate and Covered Entity any Breach of which the Subcontractor becomes aware, no later than two (2) business days after becomes aware of the Breach.

7. Mitigation and Corrective Action. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity. Business Associate shall require a Subcontractor to agree to these same terms and conditions.

8. Providing Notice of Breaches.

8.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate's employees or agents was responsible constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

8.2 If Covered Entity or Business Associate determines that an impermissible acquisition, access, use or disclosure of PHI by a Subcontractor of Business Associate constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity or Business Associate, Subcontractor shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When Covered Entity requests that Business Associate or its Subcontractor provide notice, Business Associate shall either 1) consult with Covered Entity about the specifics of the notice as set forth in section 8.1, above, or 2) require, by contract, its Subcontractor to consult with Covered Entity about the specifics of the notice as set forth in section 8.1

8.3 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

8.4 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.5 Business Associate shall notify individuals of Breaches as specified in 45 CFR § 164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business Associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. Agreements with Subcontractors. Business Associate shall enter into a Business Associate Agreement with any Subcontractor to whom it provides PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity in which the Subcontractor agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. Business Associate must enter into this Business Associate Agreement before any use by or disclosure of PHI to such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the Business Associate Agreement it enters into with a subcontractor to Covered Entity upon request. Business associate may not make any disclosure of PHI to any Subcontractor without prior written consent of Covered Entity.

10. Access to PHI. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR § 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

11. Amendment of PHI. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

12. Accounting of Disclosures. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

13. Books and Records. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary of HHS in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

14. Termination.

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 19.8.

14.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate the contract or grant without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate the contract or grant without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under the contract or grant, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

15. Return/Destruction of PHI.

15.1 Business Associate in connection with the expiration or termination of the contract or grant shall return or destroy, at the discretion of the Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this contract or grant that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

15.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI. This shall also apply to all Agents and Subcontractors of Business Associate.

16. Penalties. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations.

17. Training. Business Associate understands that it is its obligation to comply with the law and shall provide appropriate training and education to ensure compliance with this Agreement. If requested by Covered Entity, Business Associate shall participate in AHS training regarding the use, confidentiality, and security of PHI, however, participation in such training shall not supplant nor relieve Business Associate of its obligations under this Agreement to independently assure compliance with the law and this Agreement.

18. Security Rule Obligations. The following provisions of this section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

18.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that

it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

18.2 Business Associate shall ensure that any Agent and Subcontractor to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such Agent or Subcontractor. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any Agent or Subcontractor without the prior written consent of Covered Entity.

18.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an Agent or Subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident, and in no case later than two (2) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

18.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

19. Miscellaneous.

19.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the contract/grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the contract/grant continue in effect.

19.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

19.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

19.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule, and the HIPAA omnibus final rule) in construing the meaning and effect of this Agreement.

19.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

19.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity even if some of that information relates to specific services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

19.7 Business Associate is prohibited from directly or indirectly receiving any remuneration in

exchange for an individual's PHI. Business Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

19.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 12 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

ATTACHMENT F
AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT PROVISIONS (RESTATED)

1. **Definitions:** For purposes of this Attachment F, the term "Agreement" shall mean the form of the contract or grant, with all of its parts, into which this Attachment F is incorporated. The meaning of the term "Party" when used in this Attachment F shall mean any named party to this Agreement *other than* the State of Vermont, the Agency of Human Services (AHS) and any of the departments, boards, offices and business units named in this Agreement. As such, the term "Party" shall mean, when used in this Attachment F, the Contractor or Grantee with whom the State of Vermont is executing this Agreement. If Party, when permitted to do so under this Agreement, seeks by way of any subcontract, sub-grant or other form of provider agreement to employ any other person or entity to perform any of the obligations of Party under this Agreement, Party shall be obligated to ensure that all terms of this Attachment F are followed. As such, the term "Party" as used herein shall also be construed as applicable to, and describing the obligations of, any subcontractor, sub-recipient or sub-grantee of this Agreement. Any such use or construction of the term "Party" shall not, however, give any subcontractor, sub-recipient or sub-grantee any substantive right in this Agreement without an express written agreement to that effect by the State of Vermont.

2. **Agency of Human Services**: The Agency of Human Services is responsible for overseeing all contracts and grants entered by any of its departments, boards, offices and business units, however denominated. The Agency of Human Services, through the business office of the Office of the Secretary, and through its Field Services Directors, will share with any named AHS-associated party to this Agreement oversight, monitoring and enforcement responsibilities. Party agrees to cooperate with both the named AHS-associated party to this contract and with the Agency of Human Services itself with respect to the resolution of any issues relating to the performance and interpretation of this Agreement, payment matters and legal compliance.

3. **Medicaid Program Parties** (*applicable to any Party providing services and supports paid for under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver*):

   Inspection and Retention of Records: In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u).

   Subcontracting for Medicaid Services: Notwithstanding any permitted subcontracting of services to be performed under this Agreement, Party shall remain responsible for ensuring that this Agreement is fully performed according to its terms, that subcontractor remains in compliance with the terms hereof, and that subcontractor complies with all state and federal laws and regulations relating to the Medicaid program in Vermont. Subcontracts, and any service provider agreements entered into by Party in connection with the performance of this Agreement, must clearly specify in writing the responsibilities of the subcontractor or other service provider and Party must retain the authority to revoke its subcontract or service provider agreement or to impose other sanctions if the performance of the subcontractor or service provider is inadequate or if its performance deviates from any requirement of this Agreement. Party shall make available on request all contracts, subcontracts and service provider agreements between the Party, subcontractors and other service providers to the Agency of Human Services and any of its departments as well as to the Center for Medicare and Medicaid Services.

Medicaid Notification of Termination Requirements: Party shall follow the Department of Vermont Health Access Managed-Care-Organization enrollee-notification requirements, to include the requirement that Party provide timely notice of any termination of its practice.

Encounter Data: Party shall provide encounter data to the Agency of Human Services and/or its departments and ensure further that the data and services provided can be linked to and supported by enrollee eligibility files maintained by the State.

Federal Medicaid System Security Requirements Compliance: Party shall provide a security plan, risk assessment, and security controls review document within three months of the start date of this Agreement (and update it annually thereafter) in order to support audit compliance with 45 CFR 95.621 subpart F, *ADP System Security Requirements and Review Process*.

4. **Workplace Violence Prevention and Crisis Response** (*applicable to any Party and any subcontractors and sub-grantees whose employees or other service providers deliver social or mental health services directly to individual recipients of such services*):

Party shall establish a written workplace violence prevention and crisis response policy meeting the requirements of Act 109 (2016), 33 VSA §8201(b), for the benefit of employees delivering direct social or mental health services. Party shall, in preparing its policy, consult with the guidelines promulgated by the U.S. Occupational Safety and Health Administration for *Preventing Workplace Violence for Healthcare and Social Services Workers*, as those guidelines may from time to time be amended.

Party, through its violence protection and crisis response committee, shall evaluate the efficacy of its policy, and update the policy as appropriate, at least annually. The policy and any written evaluations thereof shall be provided to employees delivering direct social or mental health services.

Party will ensure that any subcontractor and sub-grantee who hires employees (or contracts with service providers) who deliver social or mental health services directly to individual recipients of such services, complies with all requirements of this Section.

5. **Non-Discrimination**:

Party shall not discriminate, and will prohibit its employees, agents, subcontractors, sub-grantees and other service providers from discrimination, on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, and on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. Party shall not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity as provided by Title 9 V.S.A. Chapter 139.

No person shall on the grounds of religion or on the grounds of sex (including, on the grounds that a woman is pregnant), be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by State of Vermont and/or federal funds.

Party further shall comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, requiring that contractors and subcontractors receiving federal funds assure that persons with limited English proficiency can meaningfully access services. To the extent Party provides assistance to

individuals with limited English proficiency through the use of oral or written translation or interpretive services, such individuals cannot be required to pay for such services.

6. Employees and Independent Contractors:

Party agrees that it shall comply with the laws of the State of Vermont with respect to the appropriate classification of its workers and service providers as "employees" and "independent contractors" for all purposes, to include for purposes related to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party agrees to ensure that all of its subcontractors or sub-grantees also remain in legal compliance as to the appropriate classification of "workers" and "independent contractors" relating to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party will on request provide to the Agency of Human Services information pertaining to the classification of its employees to include the basis for the classification. Failure to comply with these obligations may result in termination of this Agreement.

7. Data Protection and Privacy:

Protected Health Information: Party shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this Agreement. Party shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

Substance Abuse Treatment Information: Substance abuse treatment information shall be maintained in compliance with 42 C.F.R. Part 2 if the Party or subcontractor(s) are Part 2 covered programs, or if substance abuse treatment information is received from a Part 2 covered program by the Party or subcontractor(s).

Protection of Personal Information: Party agrees to comply with all applicable state and federal statutes to assure protection and security of personal information, or of any personally identifiable information (PII), including the Security Breach Notice Act, 9 V.S.A. § 2435, the Social Security Number Protection Act, 9 V.S.A. § 2440, the Document Safe Destruction Act, 9 V.S.A. § 2445 and 45 CFR 155.260. As used here, PII shall include any information, in any medium, including electronic, which can be used to distinguish or trace an individual's identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with any other personal or identifiable information that is linked or linkable to a specific person, such as date and place or birth, mother's maiden name, etc.

Other Confidential Consumer Information: Party agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to and uses of personal information relating to any beneficiary or recipient of goods, services or other forms of support. Party further agrees to comply with any applicable Vermont State Statute and other regulations respecting the right to individual privacy. Party shall ensure that all of its employees, subcontractors and other service providers performing services under this agreement understand and preserve the sensitive, confidential and non-public nature of information to which they may have access.

Data Breaches: Party shall report to AHS, though its Chief Information Officer (CIO), any impermissible use or disclosure that compromises the security, confidentiality or privacy of any form of protected personal information identified above within 24 hours of the discovery of the breach. Party shall in addition comply with any other data breach notification requirements required under federal or state law.

8. Abuse and Neglect of Children and Vulnerable Adults:

Abuse Registry. Party agrees not to employ any individual, to use any volunteer or other service provider, or to otherwise provide reimbursement to any individual who in the performance of services connected with this agreement provides care, custody, treatment, transportation, or supervision to children or to vulnerable adults

if there has been a substantiation of abuse or neglect or exploitation involving that individual. Party is responsible for confirming as to each individual having such contact with children or vulnerable adults the non-existence of a substantiated allegation of abuse, neglect or exploitation by verifying that fact though (a) as to vulnerable adults, the Adult Abuse Registry maintained by the Department of Disabilities, Aging and Independent Living and (b) as to children, the Central Child Protection Registry (unless the Party holds a valid child care license or registration from the Division of Child Development, Department for Children and Families). See 33 V.S.A. §4919(a)(3) and 33 V.S.A. §6911(c)(3).

Reporting of Abuse, Neglect, or Exploitation. Consistent with provisions of 33 V.S.A. §4913(a) and §6903, Party and any of its agents or employees who, in the performance of services connected with this agreement, (a) is a caregiver or has any other contact with clients and (b) has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall: as to children, make a report containing the information required by 33 V.S.A. §4914 to the Commissioner of the Department for Children and Families within 24 hours; or, as to a vulnerable adult, make a report containing the information required by 33 V.S.A. §6904 to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. Party will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

9. Information Technology Systems:

Computing and Communication: Party shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Party as part of this agreement. Options include, but are not limited to:

1. Party's provision of certified computing equipment, peripherals and mobile devices, on a separate Party's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.

2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

Intellectual Property/Work Product Ownership: All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement -- including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio), pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement, or are a result of the services required under this grant -- shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30-days notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Party (or subcontractor or sub-grantee), shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

Party shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State of Vermont.

If Party is operating a system or application on behalf of the State of Vermont, Party shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Party's materials.

Party acknowledges and agrees that should this agreement be in support of the State's implementation of the Patient Protection and Affordable Care Act of 2010, Party is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Such agreement will be subject to, and incorporates here by reference, 45 CFR 74.36, 45 CFR 92.34 and 45 CFR 95.617 governing rights to intangible property.

Security and Data Transfers: Party shall comply with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Party of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Party to implement any required.

Party will ensure the physical and data security associated with computer equipment, including desktops, notebooks, and other portable devices, used in connection with this Agreement. Party will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. Party will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, Party shall securely delete data (including archival backups) from Party's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

Party, in the event of a data breach, shall comply with the terms of Section 6 above.

10. Other Provisions:

Environmental Tobacco Smoke. Public Law 103-227 (also known as the Pro-Children Act of 1994) and Vermont's Act 135 (2014) (An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands) restrict the use of tobacco products in certain settings. Party shall ensure that no person is permitted: (i) to use tobacco products or tobacco substitutes as defined in 7 V.S.A. § 1001 on the premises, both indoor and outdoor, of any licensed child care center or afterschool program at any time; (ii) to use tobacco products or tobacco substitutes on the premises, both indoor and in any outdoor area designated for child care, health or day care services, kindergarten, pre-kindergarten, elementary, or secondary education or library services; and (iii) to use tobacco products or tobacco substitutes on the premises of a licensed or registered family child care home while children are present and in care. Party will refrain from promoting the use of tobacco products for all clients and from making tobacco products available to minors.

Failure to comply with the provisions of the federal law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The federal Pro-Children Act of 1994, however, does not apply to portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

2-1-1 Database: If Party provides health or human services within Vermont, or if Party provides such services near the Vermont border readily accessible to residents of Vermont, Party shall adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211 (Vermont 211), and will provide to Vermont 211 relevant descriptive information regarding its agency, programs and/or contact information as

well as accurate and up to date information to its database as requested. The "Inclusion/Exclusion" policy can be found at www.vermont211.org.

Voter Registration: When designated by the Secretary of State, Party agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

Drug Free Workplace Act: Party will assure a drug-free workplace in accordance with 45 CFR Part 76.

Lobbying: No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

Department of Vermont Health Access
Subcontractor Compliance Form (Restated)

Date: _____

Original Contractor/Grantee Name: _____ Contract/Grant #: _____

Subcontractor Name: _____

Scope of Subcontracted Services:

_____
_____
_____
_____
_____
_____
_____
_____

Is any portion of the work being outsourced outside of the United States? ☐ YES ☐ NO
(If yes, do not proceed)

All vendors under contract, grant, or agreement with the State of Vermont, are responsible for the performance and compliance of their subcontractors with the Standard State Terms and Conditions in Attachment C. This document certifies that the Vendor is aware of and in agreement with the State expectation and has confirmed the subcontractor is in full compliance (or has a compliance plan on file) in relation to the following:

- ☐ Subcontractor does not owe, is in good standing, or is in compliance with a plan for payment of any taxes due to the State of Vermont
- ☐ Subcontractor (if an individual) does not owe, is in good standing, or is in compliance with a plan for payment of Child Support due to the State of Vermont.
- ☐ Subcontractor is not on the State's disbarment list.

In accordance with State Standard Contract Provisions (Attachment C), the State may set off any sums which the subcontractor owes the State against any sums due the Vendor under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided in Attachment C.

_____ _____
Signature of Subcontractor Date

_____ _____
Signature of Vendor Date

_____ _____
Received by DVHA Business Office Date

Required: Contractor cannot subcontract until this form has been returned to DVHA Contracts & Grants Unit.